Physicians' Newsletter

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Only BC Residents are Eligible for MSP Coverage

A person must be a resident of BC to be eligible for MSP and other BC provincial health care benefits. Those who move outside BC lose eligibility as follows:

Outside Canada

Benefits continue for the balance of the month of departure.

Note: A person who chooses to reside in Washington State is not eligible for benefits, even if the person commutes to BC every day.

Within Canada

Benefits continue for the balance of the month of departure, plus two months. If requested, benefits may be approved for a further three months to cover a person while in transit.

If you have a patient who has permanently moved outside BC and is no longer eligible for coverage, MSP must not be billed for any services provided.

Contact

Please notify the Ministry of Health's Investigations Unit if you know or believe that a person who is ineligible for provincial health care coverage is seeking medical services through MSP.

If you wish, your report can be made to the Investigations Unit in confidence.

Telephone: 604 660-2406 Fax: 604 660-3083

Physicians' Newsletter gets a Fresh New Look

Our look may have changed but you can still count on us to bring you the latest Medical Services Plan news and

Changes to Explanatory Codes

Updated explanatory code:

LH Fee items 01065, 01164 and 01165 are only applicable to general, regional and monitored anesthesia care.

New explanatory codes:

D9 Original claim is at WCB and your debit request has been forwarded to WCB.

MW This OSMV form fee is not payable on the same date of service as another OSMV form fee that you have billed.

MX Driver's licence number is not numeric, is missing or is not located in the first seven spaces of the note or comment field.

MY A repeat OSMV form fee is not payable to any practitioner within 3 months.

MZ Insurer is invalid for this service.

NQ The incentive for full service GP obstetrical delivery bonus is payable for the first delivery the GP attends on the date billed.

NR The incentive for full service GP obstetrical delivery bonus is payable to a maximum of 25 bonuses per calendar year.

Q1 Long-term care institution visits have been paid during the time you are billing for home visits. Please verify location of service.

Q2 Home visits have been paid during the time you are billing for long-term care institution visits. Please verify location of service.

X0 Fac – Prac or Payee fac not connected.

The following explanatory codes have been reworded:

RZ A visit is not payable in addition to an OSMV* or MHR form fee when the patient is seen for the same diagnosis.

WU Unknown reason for refusal or change to fee item and/or amount. Please contact WCB.

YF Fee item/PHN valid for WCB claim only.

**Note: OSMV – Office of the Superintendent of Motor Vehicles*

Diagnostic Facility Capacity

For the purposes of Section 43(1)(e)(ii) of the Medical and Health Care Services Regulation, the MSC considers the following to constitute a "significant change" to the capability or capacity of a diagnostic facility to perform diagnostic services:

- For a specimen collection station, the addition of one or more phlebotomy chairs.
- For a diagnostic imaging facility, the addition of one or more pieces of diagnostic equipment (i.e. X-ray unit, Gamma camera, etc.)
- For any diagnostic facility, any change(s) made to the operation of the facility (including by upgrading or replacing equipment or by retaining additional employees) that results in a level of throughput that exceeds approved monthly levels by 20 percent or more. Throughput is defined as the number of services billed to MSP per facility approval category.

For the purposes of Section 43(1)(e)(ii) of the Medical and Health Care Services Regulation, the MSC considers the following to constitute a significant change in the operating hours of a diagnostic facility:

- Any change to the operating hours of a facility that results in a 20 percent or greater increase in the total weekly operating hours.

Health InsuranceBC

Your connection with Medical Services Plan and PharmaCare.

Health Insurance BC: Changes to the MSP Phone and Fax Numbers

Health Insurance BC (HIBC) is the new name for the administrative operations of the Medical Services Plan (MSP) and PharmaCare, including Fair PharmaCare.

In April 2005, HIBC introduced a new toll-free telephone service for health care providers and beneficiaries. To ensure a smooth transition, existing Ministry of Health phone and fax numbers were forwarded to the new HIBC numbers.

In an effort to consolidate and simplify the HIBC MSP numbers, the Ministry of Health phone and fax numbers will be retired effective **November 1, 2006.**

During the introduction of the new toll-free telephone service, improvements were also made to the HIBC MSP telephone menu. A single point of access became available for Health Care Providers through a Greater Vancouver local phone number and a toll-free access for areas outside of Greater Vancouver.

The following MSP Phone Numbers will be retired, effective November 1, 2006:

NUMBER TO BE RETIRED	DESCRIPTION	NEW NUMBER
250 952-2654	Providers Telephone Menu	604 456-6950 Vancouver 866 456-6950 Toll-Free
250 952-2668 800 663-7206 Toll-Free	Teleplan	604 456-6950 Vancouver 866 456-6950 Toll-Free
250 952-3101	Fax - Provider Programs	250 405-3592
250 952-3051	Fax - Adjudication	250 405-3591
250 952-3222	Fax - Benefit Services	250 405-3593
250 952-3032	Fax - Cosmetics	250 405-3590
250 952-2964	Fax - Out of Country	250 405-3588

Please note that Teleplan Support will no longer have a separate phone number. To reach Teleplan Support through the new telephone menu system, at the main menu:

- press 3 for Provider Services
- then press 2 for Teleplan

Follow the menu prompts to reach other areas in MSP.

To avoid any confusion in the future, please take a moment to remove the retired HIBC phone and fax numbers from your contact lists and add the new numbers.

PharmaCare

PharmaCare Management Changes

PharmaCare is now part of a new division with its own Assistant Deputy Minister. **Bob Nakagawa** is now the ADM of the new Pharmaceutical Services Division, which includes both PharmaCare and the B.C. National Pharmaceuticals Strategy Secretariat.

Suzanne Solven recently returned to her position as Executive Director, PharmaCare.

Heather Davidson, who had been A/Executive Director for the past year, has accepted a position as Executive Director of Housing Policy with the Ministry of Forests and Range.

Andrew van der Gugten is the A/Executive Director of the National Pharmaceuticals Strategy Secretariat.

Cyclosporine – Clarification of Coverage Policy

As communicated in the previous issue of this newsletter, all brand name and generic strengths of cyclosporine capsules were included in the PharmaCare Low Cost Alternative (LCA) Program effective November 25, 2005. As result, some cyclosporine capsules became partial benefits.

IMPORTANT: Patients who were receiving Special Authority (SA) coverage of Neoral® 25mg, 50mg, and 100mg capsules before November 25, 2005, were not affected. They continue to receive full benefit coverage of these products under indefinite PharmaCare SAs.

For patients who did not already have SA coverage of Neoral® as noted above and for claims for all first-time prescriptions, cyclosporine capsules are now reimbursed according to the rules of the LCA Program as follows:

NEW CATEGORY (Chemical Name)	DIN	MAN	BRAND NAME	LCA STATUS	PRICE
*Cyclosporine Cap 25mg	2247073	SAN	Sandoz-Cyclosporine Cap 25mg	F	
	2150689	NVR	Neoral® Cap 25mg	P	$1.0327
*Cyclosporine Cap 50mg	2247074	SAN	Sandoz-Cyclosporine Cap 50mg	F	
	2150662	NVR	Neoral® Cap 50mg	P	$2.0135
*Cyclosporine Cap 100mg	2242821	SAN	Sandoz-Cyclosporine Cap 100mg	F	
	2150670	NVR	Neoral® Cap 100mg	P	$4.3163

- Requires Special Authority (for criteria and forms, please refer to the PharmaCare website at: www.health.gov.bc.ca/pharme/sa/saindex.html

Inclusion of Tamiflu® as a PharmaCare Benefit

On November 15, 2005, Tamiflu® (oseltamivir phosphate) 75mg capsules and Tamiflu® 12mg/ml suspension became benefits under PharmaCare Plan B (Permanent Residents of Licensed Long-Term Care Facilities) for prophylaxis and treatment during outbreaks of Influenza A or Influenza B for the 2005/06 influenza season. Hoffmann-La Roche Limited, manufacturer of Tamiflu, has advised PharmaCare that long-term care facilities have been apprised of how to access the product during outbreaks of Influenza A and B. The Roche Order Management line contact number is 1-800-268-0440.

BC Palliative Care Drug Plan (Plan P)

Determining Patient Eligibility

We would like to remind physicians of the eligibility criteria for the BC Palliative Care Drug Plan. Coverage under the plan is available to B.C. residents who:

- are enrolled in the Medical Services Plan,
- are living at home[1],
- have been diagnosed with a life-threatening illness or condition,
- have a life expectancy of up to six months[2], and
- consent to the focus of care being palliative rather than treatment aimed at cure.

Plan P Formulary Information

As with benefits for other PharmaCare plans, changes to the formulary will be announced in the PharmaCare Newsletter which is made available on the PharmaCare website at www.health.gov.bc.ca/pharme/newsletter/index.html.

An e-mail notification service is available if you would like to be notified when a new edition of the PharmaCare Newsletter is published on the website. Visit the PharmaCare homepage at www.health.gov.bc.ca/pharme to subscribe.

Please note that:

- In addition to designated prescription drugs, certain over-the-counter medications are included in the Plan P formulary.
- The over-the-counter medications in the formulary are covered for Plan P patients only.
- The patient will require a prescription to receive coverage of an over-the-counter drug included in the Plan P formulary.
- All over-the-counter medications included in the BC Palliative Care Drug Plan formulary are now subject to the Low Cost Alternative (LCA) Program.

Additional information on the plan, including information on correctly determining patient eligibility, is available on the PharmaCare website at: www.health.gov.bc.ca/pharme/outgoing/palliative.html.

[1] "Home" is defined as wherever the person is living, whether in their own home, with family or friends, in a supportive living residence, or some hospice facilities.

[2] To determine a patient's medical eligibility, please refer to the Palliative Performance Scale in Appendix A of the Physician Guide available at: www.health.gov.bc.ca/pharme/outgoing/palliative_physguide.pdf.

Methadone 2mg/ml

Prescriptions under the PharmaCare Methadone Maintenance Program must be for the 1 mg per ml strength, as per federal guidelines.

Physicians require prior approval from the College of Physicians and Surgeons to prescribe methadone. If the College provides you with approval to prescribe in a concentration greater than 1 mg per ml, you can request Special Authority coverage from PharmaCare for your patient. Methadone 2mg/ml is a benefit only for patients who have an approved PharmaCare Special Authority.

Billing Seminars for Medical Office Assistants – *New Initiative*

We are pleased to inform you of an exciting initiative under development in collaboration between MSP and the British Columbia Medical Association/Ministry of Health Joint Utilization Committee. Following the success of previous billing seminars we are preparing to launch a new series of seminars for medical office staff. Topics will focus on proper procedures and rules for billing "difficult" fee-for-service claims and medical office assistants (MOA's) will have an opportunity to meet with Ministry representatives who will be on hand to answer questions.

The objectives of the seminars are to:

- improve consistency of billing information distributed to medical offices in British Columbia
- provide MOA's with an opportunity to meet with MOH/MSP staff and ask questions
- help to increase the accuracy of claims submitted to MSP to reduce the number of rejections received by physician offices
- provide the Ministry with an opportunity to identify new issues or concerns

If you or your medical office assistant would be interested in attending a session, please complete the *Billing Seminar Needs Assessment* included in this issue of Physicians' Newsletter. The assessment includes a list of suggested seminar topics, locations and times.

We appreciate your feedback – please fax the completed assessment back to Medical Services Operations and Policy, Ministry of Health 250 952-3133 or for questions call 250 952-1059.

Treatment of a Post-Mastectomy Seroma

The Section of General Surgery requested clarification on whether treatment of a post-mastectomy seroma by aspiration is considered a complication and if visits for aspiration are billable.

It was determined that intervention of post mastectomy seroma by aspiration should be considered outside of the normal scope of the 42 day post-operative period. These conditions generally occur subsequent to discharge from hospital. It was agreed that it would be appropriate to bill for this service under fee item T07041 – Aspiration – abdomen or chest, operation only. A major tray fee may also be claimed under fee item 00090, if the service is provided outside of a publicly funded facility but a visit fee would not be payable in addition to the procedure in accordance with Preamble B.9.d (operation only).

Newfoundland and Labrador – Beneficiary Re-registration

The Medical Care Plan (MCP) card is the key to the health care system, providing eligible residents of Newfoundland and Labrador with access to comprehensive health care coverage. The last full registration of the population was done in 1969 and as records no longer adequately reflect current population statistics MCP must now undertake to re-register all eligible residents of the province.

To accommodate this re-registration process a new MCP card has been designed. It contains additional information such as date of birth and gender and, as well, every card will contain effective and expiry dates. These added security features will help ensure that only the person to whom the card is issued will be able to use it. During the initial re-registration phase expiry dates will be staggered over a 1 to 5 year period and thereafter every 5 years.

All eligible residents should be re-registered by March 31, 2007. After this date all currently existing MCP cards will no longer be valid. Starting April 1, 2007, as your patients present for treatment you should ensure they have the new and valid MCP card.

Billing Tips

Fee item 70019-Certified Surgical Assistant

Fee item 70019 - Certified Surgical Assistant fee may be billed with any "C" prefix surgery as listed in the Medical Services Commission Payment Schedule. Payment may also be made for this fee when not billed with a "C" prefix surgery if a certified surgical assistant is necessary due to the medical condition of the patient or if there are exceptional circumstances in a particular case. The details/explanation should be provided in the electronic note record, it is not sufficient to say a "certified surgical assistant was required, increased complexity or new advanced complex surgery".

Reference: Preamble B.9.f.iv.
The specialist's assistant listings apply only to surgical procedures having unusual technical difficulties such that the services of a certified surgical assistant are necessary. The general assistant listings are applicable to all other situations where surgical assistance is necessary. (Also see paragraph 14 – Prefixes to Fee Codes).
C-designates fee items for which it is not required to indicate by letter the need for a certified surgeon to assist at surgery (see fee item T70019).

Diagnostic Code 780

The use of diagnostic code 780 or 999 is not appropriate when billing for a visit and a procedure or a visit and a form fee. Please use the diagnostic code corresponding to the medical condition for the visit otherwise the visit will be refused with explanatory code KB (Visits and minor procedures, same diagnosis – larger fee only is paid. Different diagnosis – lesser fee paid at 50%) or RZ (A visit is not payable in addition to a OSMV or MHR form fee when the patient is seen for the same diagnosis).

Third-party Mental Competency Examinations and Reports

The families or guardians of patients suffering from dementia often request family physicians or psychiatrists to perform a mental status examination to assess and document the patient's competency in respect to managing personal financial affairs. Physicians should note that examinations and reporting solely for this purpose are considered to be a third-party matter and should not be billed to MSP.

Labelling Pap Tests

The BC Cancer Agency has recently informed MSP that a significant number of samples arrive at their lab without the physician's information clearly marked on the sample. This results in a delay providing test results to physicians. Please ensure that each sample is clearly labelled with the physician's information when submitting to BCCA for testing to ensure test results are not unnecessarily delayed.

Reminder: Application for benefits under the BCMA Maternity Leave Benefit Program

Are you a medical practitioner having a baby or planning a pregnancy in the period of April 1, 2006 to March 31, 2007? If you are, then it is important to take advantage of the Maternity Leave Benefit Program (MLBP) funded by the provincial government and administered by the BCMA. The MLBP ensures that a new mother can recover from pregnancy and delivery.

For more information, contact:

Lorie Arlitt, MLBP Administrator
Toll Free in BC: 1 800 665-2262
Ext 2882
Direct Line: 604 638-2882
Email: larlitt@bcma.bc.ca

Minor Treatment Units

The Health Authorities have introduced "Minor Treatment Units" to deal with emergency patients who do not require admission to hospital. The Medical Services Branch would like to remind Health Authorities that any associated diagnostic services (laboratory services, x-ray, etc.) provided in these Minor Treatment Units are not billable to MSP. Physician services should be billed in accordance with Emergency Room Service listings.

Introduction of Revised Location Codes for MSP Claims

The graduated process to introduce revised location codes for all claims billed to MSP is now underway and going well. This revision is being implemented to assist with identifying the specific locations where publicly funded MSP services are provided. MSP appreciates the support and efforts of practitioners and Medical Office Assistants, resulting in a smooth transition to the revised codes.

Dates to remember:

- March 1, 2006, MSP began accepting claims (with dates of service March 1 or later) containing the revised location codes, in addition to existing codes.
- The transition period is in effect until October 1, 2006, for all practitioners to switch to using the revised codes exclusively.
- After October 1, claims that do not contain the revised codes will be refused and must be resubmitted with the correct code.

Details of changes to location codes may be found in the Memorandum to All Practitioners dated February 8, 2006. A copy of this memo is posted on the MSP Web site at: http://www.health.gov.bc.ca/msp/infoprac/index.html

The location code revision is considered to be a routine update to Teleplan specifications. Vendors are upgrading their software to reflect the revised codes and practitioners are receiving the upgrades according to the established schedule of their software maintenance contracts.

In general, the key point to remember when choosing a location code is that it should reflect the actual place where the service is performed. Two specific questions that require clarification have emerged since the transition began:

- **Laboratory Specimens** – Example: If a laboratory specimen is collected at a residential care facility then taken to a hospital laboratory for processing, the code to use is "P" (Hospital – Outpatient), because the diagnostic service is performed at the hospital for a non-admitted patient. A diagnostic facility that is privately owned, with a separate MSC Certificate of Approval should use code "D" when submitting claims for diagnostic services provided at that facility.
- **Mental Health Facilities** – Example: Facilities that perform crisis stabilization services, where patients may be admitted for short periods, are not considered to be primarily residential in nature and should use code "M" (Mental Health Centre) when services are billed. Residential mental health facilities should use code "C".

Questions about the revised codes may be directed to:
Medical Services Operations and Policy/Ministry of Health
Telephone: 250 952-1769

Change of Location

If the location or facility where a patient is receiving medical care is changed, this information should be included in a note record for each claim billed to MSP. If a patient is in acute care and is then transferred to intermediate or extended care there should be a note record included with each claim. This also applies when a patient is transferred from one hospital to another or from one city to another. This change of location could impact the fee item payable by MSP. For example:

If a patient is transferred from Penticton Regional Hospital to Vancouver General Hospital a note record indicating the name of each facility and the date of transfer should be included with each claim.

Audit Reports

Dr. A. – Ophthalmology
A specialist came to the attention of the Billing Integrity Program as the result of a service verification survey that indicated that MSP was being billed for uninsured services. The onsite audit by a peer specialist found that the physician had claimed for botulinum toxin injection for treatment of migraine headaches. The use of botox for the treatment of migraines is not an insured service of MSP.

The MSC and the physician arrived at a negotiated settlement in which the physician agreed to repay the MSC $35,000, inclusive of costs, and abide by a pattern of practice order in which the physician would not bill MSP for uninsured services.

Dr. B. – Internal Medicine
A sub-specialist who billed from the Internal Medicine fee item listings came to the attention of the MSC's Audit and Inspection Committee because of a disproportionately high rate of 00310 consultations billings, relative to the rates for 00312 limited or repeat consultations and 00307 subsequent office visits. Inspection of medical records found many of the consultations should have been billed as lesser services. In one example, the consultation report comprised only 5 sentences.

The parties agreed to submit the case to non-binding mediation. This resulted in a negotiated settlement in which the practitioner agreed to repay the MSC $80,000, inclusive of costs and interest, abide by a patterns of practice order requiring the practitioner to maintain adequate medical records and to bill only a limited or repeat consultation or lesser service when the visit is less demanding and normally requires substantially less time than a full consultation.

Dr. C. – General Practice
An audit of a general practitioner found an inappropriately high rate of billings for complete physical examinations and counselling, when a visit fee item of lesser value would have been more appropriate. As well, there was pattern of 'family constellation' claims, representing unnecessary concurrent care provided to members of the same family or household during the same encounter. The peer medical inspector also found errors regarding missing or inadequate medical records.

As a result of a mediated settlement, the physician agreed to repay the Commission $52,000, inclusive of costs and abide by a pattern of practice order whereby adequate medical records will be maintained and claims will be submitted in accordance with the MSC Payment Schedule.

Dr. D. – Ophthalmology
An ophthalmologist providing uninsured laser refractive surgery was audited after the Commission received complaints that the physician submitted claims to MSP for unnecessary eye examinations rendered in association with uninsured refractive surgery. As a result of a negotiated settlement, the physician agreed to repay the Commission $5,017, inclusive of costs and abide by a pattern of practice order in which the physician will:

- maintain adequate medical records in accordance with the MSC Payment Schedule Preamble B.2;
- submit claims for insured services, in association with uninsured laser refractive surgery, only when the insured services are medically necessary and in accordance with MSC Payment Schedule Preamble part A.1 and the Ophthalmology Preamble.
- provide written notice to affected patients at the time of service whenever a claim will be submitted to MSP in association with an uninsured service, inform them of their clinically significant diagnosis, and explain the purpose and necessity of the insured service. The notice will be retained on the patients' medical record.

Dr. E. – General Practice
A general practitioner engaged in both family and emergency medicine was audited by the MSC because of adverse results of a service verification survey and high rate of Level II and Level III Emergency Care billings. Different peer medical inspectors audited the family and emergency components of the physician's practice separately. The family practice inspector found inadequate records and/or billing errors in respect to counseling and uninsured 3rd party forms, while the emergency medicine inspector found ER visits payable as lesser levels of care.

As the result of a negotiated settlement, the physician agreed to repay the MSC $35,800, inclusive of costs, surcharge and interest, and comply with a pattern of practice order in which the physician would maintain adequate medical records that substantiated the claimed services and comply with the MSC Payment Schedule, in respect to general practice and emergency medicine listings.

MSP BULLETIN
Summer 2006

The Medical Services Plan's "Bulletin" is provided to help physicians identify patients whose MSP benefits have payment restrictions. This Bulletin provides important billing information for physicians only. Thank you for respecting the confidential nature of this information.

The Bulletin is an updated listing of restricted MSP enrollment numbers for clients who have signed a legal "Agreement of Limitation" form, which limits MSP payment responsibilities to one primary care physician. If care is provided by other physicians, the charges must be made directly to the clients. MSP will not accept payment responsibility unless special circumstances are clearly stated. An example of this would be medical care that has been provided by an emergency physician in the hospital emergency room.

MSP is concerned about the potential misuse of CareCards and strongly recommends a complete check of CareCard information at all first appointments. If you suspect any unusual use of a CareCard, please request a second piece of picture identification in order to verify that the CareCard is being presented by the person named on the card.

PHN	Birthdate (MM/YY)	Sex (M/F)	Physician Number
9013676868	12/54	M	06541
9023967395	02/54	F	03023
9025293026	12/58	M	24287
9029287062	06/52	F	06061
9029596344	09/55	M	00792
9030165823	12/54	F	05334
9030205973	05/54	M	26411
9030780581	05/29	F	08241
9030861738	10/45	M	01604
9032398914	08/56	M	09760
9032842679	05/59	F	01229
9034248181	10/59	F	07834
9034793801	06/59	F	06468
9041726364	07/56	F	03733
9071584167	06/48	M	09604
9104870848	04/67	F	09443
9107346403	08/54	M	08365

Out-Patient Diagnostic Requisition Forms

The Medical Services Commission has approved the new and/or amended out-patient diagnostic requisition forms included with this newsletter. All laboratories must be using the new and/or amended requisition forms by October 1, 2006.

Standard Out-Patient Laboratory Requisition

The following updates were made to the Standard Out-Patient Laboratory Requisition (SOPLR):

1) The ESR tick box was removed
2) The addition of a "Warfarin" tick box has been added so that Laboratories can report either a reference range (for pts not on Warfarin) or a therapeutic range (for pts on Warfarin)
3) The following addition to the demographic area of the SOPLR - "if this is a STAT order please provide contact phone #".

Standard Out-Patient Bone Densitometry Requisition

In July of 2005, a Guideline and Protocol was released for Bone Density Measurement in Women. As a result, the Standard Out-Patient Bone Densitometry Requisition was revised.

Standard Out-Patient Requisition for Adult Polysomnography or Multiple Sleep Latency Test

The Medical Services Commission approved the Sleep Laboratory Services (Polysomnography) for Adults – Standards for Waitlist Management and Access report submitted by the Polysomnography Expert Working Group on June 22, 2005. The new Adult Polysomnography or Multiple Sleep Latency Test Requisition was developed in conjunction with the Standards report.

Name Change for the Worker's Compensation Board - WorkSafeBC

The Worker's Compensation Board has recently changed their agency name to "WorkSafeBC". The acronym "WCB" (i.e. Insurer Code area) has been replaced with the term "WorkSafeBC" on all Out-Patient Diagnostic Requisition Forms.

Note: Copies of forms are included in this issue of Physicians' Newsletter.

List of Inserts:

- Medical Practice Access to PharmaNet
- New Driver Fitness Assessment Payment (DFAP) Policy and Driver Medical Exam (DME) forms completed by General Practitioners
- Update to the Medical Services Commission Payment Schedule
- Full Service Family Practice Incentive Program
- Billing Seminar Needs Assessment
- Three Requisition forms:
  1. Standard Out-Patient Laboratory Requisition
  2. Standard Out-Patient Bone Densitometry Requisition
  3. Standard Requisition for Adult Polysomnography or Multiple Sleep Latency Test

Use of PharmaNet Information

We would like to remind all PharmaNet users that information obtained from PharmaNet is intended as a supplement to, rather than a substitute for, the knowledge, expertise, skill and judgment of pharmacists, physicians and other health care professionals.

Information on PharmaNet is not exhaustive and therefore cannot be relied upon as complete. Please also note that the absence in PharmaNet of a warning about a drug or drug combination is not an indication that the drug or drug combination is safe, appropriate or effective in any given patient.

Before making patient care decisions, health care professionals should confirm any information obtained from PharmaNet and ensure that no additional relevant information exists.

2006 *Letter of Agreement* among the BC government, BC Medical Association & the Medical Services Commission

On May 4, 2006, the membership of the BCMA approved a new tentative agreement with the provincial government. The six-year agreement will improve health care delivery to British Columbians by providing more resources to support full service family practice and more funding to increase patient access to specialty care physicians. The agreement has defined provisions until March 31, 2012, and re-opener provisions for compensation in the 2010-11 and 2011-12 fiscal years.

This agreement also establishes the principles and process for the negotiation of a new *Physician Master Agreement* that supports a trilateral relationship between physicians, the government and health authorities. This will occur over the next twelve months. The principles established will facilitate collaboration and cooperation between the government, the BCMA, health authorities and physicians.

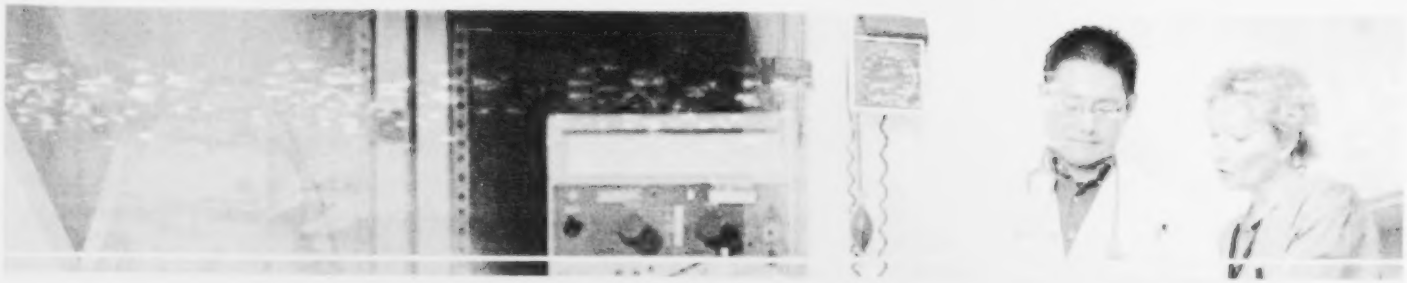
By the fourth year of the agreement, expenditure on physician services will have increased by about $500 million to approximately $3 billion.

These highlights are for general information only. If there are any discrepancies, the *Letter of Agreement* will take precedence.

The new agreement features:

- General compensation increases of 3%, 2%, 2% and 3% over the first four years with a re-opener for years five and six (the first increase is effective April 1, 2006);
- Incentives and targetted funding to bring the total increase by year four to about 19%;
- Maintenance of protections and benefits of the Second Master Agreement;
- Increase in funding for physician benefits for the full six years;
- Additional improvements to the Contributory Professional Retirement Savings Plan Agreement in year five;
- Change from maternity leave to parental leave in year five;
- Increase in funding to maintain the value of rural programs;
- Support for access and improvement to specialist services;
- Support for access and improvement to full service family practice;
- Enabling shared care and appropriate scopes of practice among general practitioners, specialist physicians and other health care professionals;
- Funding for expansion of alternative payment plans to enhance patient care;
- Review of the Medical On-Call/Availability Program; and
- Support for use of electronic technology in physician practices.

For more information, please view the Frequently Asked Questions (FAQs) located on the BC Ministry of Health website at http://www.health.gov.bc.ca/msp/legislation/bcma_2006loa.html.



Medical Practice Access to PharmaNet

Providing physicians with access to PharmaNet from their medical offices

PharmaNet is a world class system that records information on all prescriptions dispensed in community pharmacies in British Columbia. The Ministry of Health has launched a new service, Medical Practice Access to PharmaNet (MPAP). This service provides physicians with access from their medical offices to patient medication profiles that include all dispensed medications.

A number of measures are in place to protect patient privacy, including strong security, encryption of transmitted patient data, formal processes to control access, and provisions for patients to lock access to their profiles with a keyword.

This new eHealth service enables physicians to access patient medication profiles

Physicians who have access to patient medication profiles from their medical offices reap several benefits in dealing with their patients:

> They do not need to rely on a patient's memory of the medications dispensed to them. A patient's PharmaNet profile provides a more accurate and complete record. Access to this information is vital, especially if language barriers or impaired mental acuity hamper a patient's ability to communicate accurately.

> The profile shows other medications that may have been prescribed by a specialist, other health care practitioners, or by a walk-in clinic the patient may have visited. Often the family physician may be unaware of these medications.

> The profile provides a real-time, up-to-the-minute record of all drugs that have been dispensed to a patient. Consequently, the physician can immediately identify potential drug-seeking individuals.

> Online availability of this information can reduce the need to call the patient's pharmacy for clarification.

The College of Physicians & Surgeons of British Columbia has worked with the Ministry of Health on medical practice access and supports the expansion of PharmaNet to medical practices throughout British Columbia.

The province of British Columbia is committed to providing complete, comprehensive and innovative solutions for health care providers.

Medical Practice Access to PharmaNet is just one of a number of initiatives being undertaken over the next three years to improve access to information and provide an Electronic Health Record that will link clinics, medical practices, hospitals, Provincial Health Services agencies, pharmacies and other sites where patients receive health care services.

Ministry of Health – PharmaNet

BRITISH COLUMBIA

How does Medical Practice Access to PharmaNet (MPAP) work?

When prescription drugs are dispensed at a B.C. community pharmacy, they are entered into the PharmaNet system. PharmaNet can store a history of the medications dispensed to a patient.

MPAP assists physicians in medication management by providing point of care access enabling them to:

> Obtain a record of all medications dispensed to a patient at any community pharmacy in the past 14 months;

> Request a Drug Utilization Evaluation (DUE) against the patient's medication history for any new prescription;

> Update a patient's medication profile with drugs administered or drug samples provided in the office.

MPAP provides access to PharmaNet from computers in a medical practice using software provided by an approved vendor (see information below).

To protect patient privacy, patients must provide written consent for each physician who will access their information. The patient's consent needs to be collected only once. This requirement complies with the Freedom of Information and Protection of Privacy Act and the Personal Information Protection Act. For general information, visit the PharmaNet page on the PharmaCare website at: www.health.gov.bc.ca/pharme/pharmanet/netindex.html.

The Province of B.C. continues to work on enhancements to its Provincial Drug Information System.

Enhancements will include:

- Electronic prescribing from a prescriber's office
- More complete and comprehensive patient medication profiles
- Access to clinical decision support tools
- Access to the provincial formulary, the ability to check a patient's eligibility for a drug and PharmaCare Special Authority support

What is required to access the MPAP service?

Each physician working at a medical practice needs to register for MPAP individually.

1) Visit the MPAP website at: www.health.gov.bc.ca/ehealth/das/medpract.html.

2) From the list of software vendors approved by the Ministry of Health, choose and contact the vendor from whom you will obtain the software for your connection to PharmaNet. There is no cost from the Ministry of Health for access to PharmaNet, the only cost for the physician is their hardware and software to link to PharmaNet.

3) Complete a registration form online identifying all individuals who will access PharmaNet on the physician's behalf.

4) Complete and sign a Data Access Agreement and mail it to the Ministry of Health.

When the registration form and Data Access Agreement have been processed, the Ministry of Health's Data Access Services team will work with you to establish your connection to PharmaNet. For further information, contact us at HLTH.DataAccessServices@gov.bc.ca.

The use of PharmaNet is not intended as a substitute for professional judgment. Information on PharmaNet is not exhaustive and cannot be relied upon as complete. The absence of a warning about a drug or drug combination is not an indication that the drug or drug combination is safe, appropriate or effective for any given patient. Health care professionals should confirm information obtained from PharmaNet, and ensure no clinical risk or alternative exists, before making patient care decisions.

Ministry of Health – PharmaNet

BRITISH COLUMBIA

NEW Driver Fitness Assessment Payment (DFAP) Policy and Driver Medical Exam (DME) forms completed by General Practitioners

Effective June 1 2006 the Office of the Superintendent of Motor Vehicles (OSMV) will pay for certain driver fitness assessments including DMEs required for people with medical conditions. OSMV is making this change in response to a BC Human Rights Tribunal decision that established the principle that it is discriminatory to make drivers with medical conditions pay for tests required to assess their fitness to drive.

Background

The OSMV's driver fitness program identifies and assesses drivers to determine that they are physically, cognitively and medically fit to drive. The OSMV may require a DME form to be completed by a general practitioner:

1. when an applicant for a BC driver's licence declares a medical condition or disability affecting driving
2. when a reliable report of a potential condition that may affect fitness to drive is received from a medical professional, police officer, concerned family member or other individual and more information is required
3. at regular intervals beginning at age 80 as this is an age where medical conditions affecting driving are more common
4. when a person applies for a commercial class driver's licence, and
5. at regular intervals for commercial class driver's licence holders in keeping with the National Safety Code (NSC) schedule for medical examinations.

Current practice is for GPs to directly bill their patients for completing DME forms.

What has not changed

OSMV will continue to issue and require DMEs for commercial driver applicants and on a regular schedule for commercial drivers and drivers beginning at age 80 (#3, 4 and 5 above).

OSMV will not pay for these DMEs and GPs will continue to directly bill their patients for these exams.

GPs should continue the current practice of filling out the DME form in its entirety and sending it to OSMV, as per the physician instructions on the form.

NEW: What is changing

As of June 1 2006, the OSMV will pay for DMEs required of drivers with known or possible medical conditions (#1, 2 above) - a doctor may not charge a driver an additional fee for these DMEs.

A visit by a driver to a GP for the purpose of having the doctor complete the DME report is not considered a visit/treatment or a procedure under MSP billing policy. This means a physician may bill MSP for a medically necessary visit (e.g. a sore throat) for the same

patient on the same day as the completion of a driver medical exam as long as the reasons for the visit and for the driver exam are unrelated.
OSMV will reimburse doctors for completing DMEs through the existing MSP billing process. To submit your claim to MSP for payment, please follow the instructions on the attached sheet.

The DME form has been updated to reflect the new payment policy. Effective June 1 2006 the DMEs paid by OSMV will be printed on a blue form with:

- a statement that the driver's medical exam is paid for by the OSMV
- an MSP Fee Code for billing purposes, and
- a place for you to input your patient's Personal Health Number (PHN).

The expectation of the OSMV is that the DMEs for drivers with medical conditions will generally be a limited examination, for a specific reason, and that physicians are not expected to complete a full physical. The word 'generally' is used, however, to acknowledge physician discretion. The medical reason for the DME, e.g. 'cardiovascular' will be printed on the form in order to focus the examination. The instructions on the new blue DME form make it clear that we want the exam to focus on the condition being monitored.

What is the payment for completing a fitness assessment?

Type of Assessment	**Payment**
Driver's Medical Examination (DME) form	$75
Diabetic Driver Report – stand-alone [this is rarely used and only applies to diabetic commercial drivers under certain circumstances]	$75
Diabetic Driver Report – attached to DME [only applies to diabetic commercial drivers] **Note**: When the Diabetic Driver Report is attached to the DMER, the total value of this visit is actually $105 ($75 for DMER + $30 for Diabetic Driver Report = $105.00).	$30

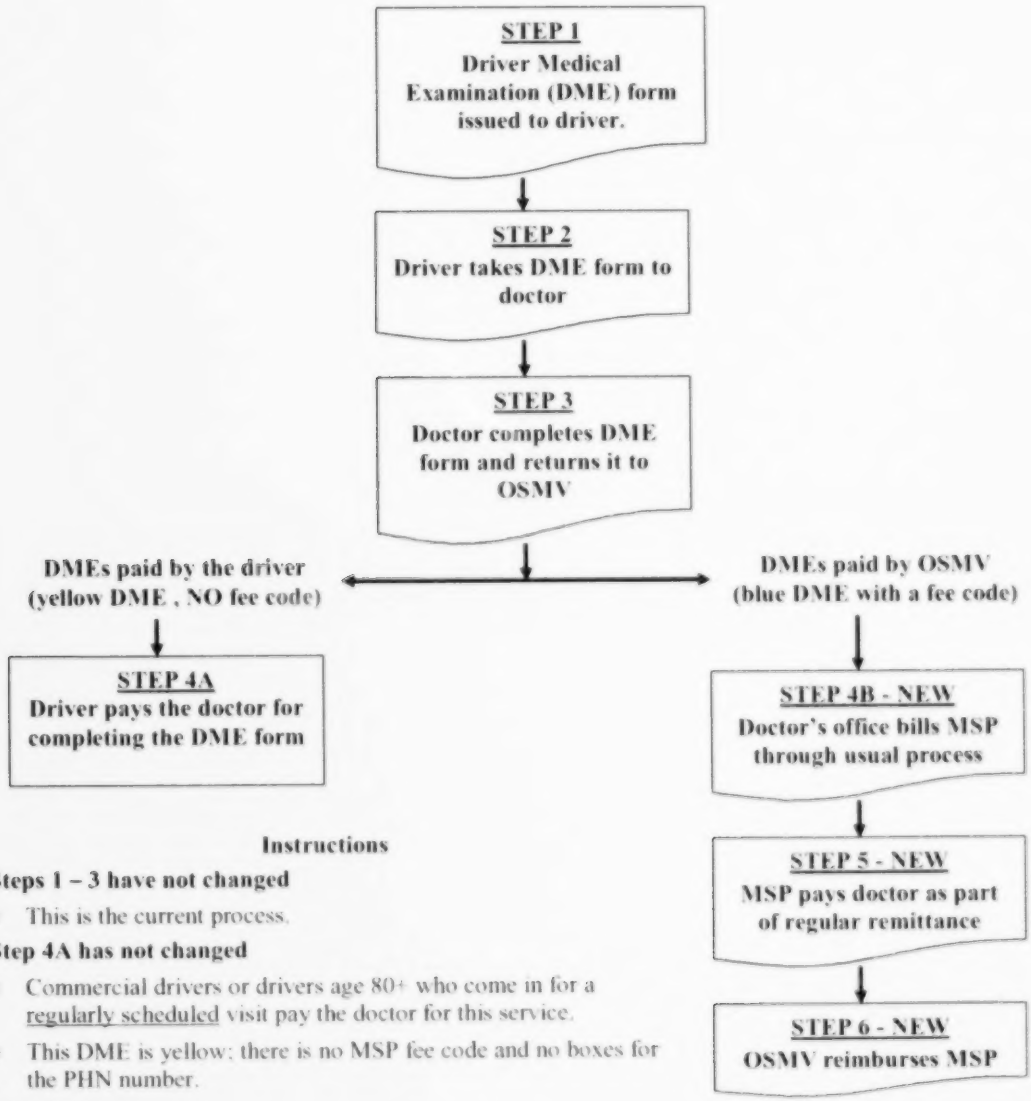
In force date
The payment policy is in effect for DMEs issued from June 1, 2006 onwards.

Forms issued prior to June 1st but completed after June 1st will not be paid. Only forms that say "Paid for by the OSMV" can be processed through MSP.

The OSMV has arranged a dedicated phone line until September 1 2006 should you have questions or concerns. The number is 250 356-5964 (Victoria).

The Driver Fitness Program exists to enhance public safety by ensuring drivers are fit and able to drive safely, thereby preventing accidents and injuries. Its success depends in part on the cooperation and support of physicians.

Summary of the billing and payment process for DMEs paid by OSMV


STEP 1
Driver Medical Examination (DME) form issued to driver.
STEP 2
Driver takes DME form to doctor
STEP 3
Doctor completes DME form and returns it to OSMV
DMEs paid by the driver (yellow DME , NO fee code)
DMEs paid by OSMV (blue DME with a fee code)
STEP 4A
Driver pays the doctor for completing the DME form
STEP 4B - NEW
Doctor's office bills MSP through usual process
STEP 5 - NEW
MSP pays doctor as part of regular remittance
STEP 6 - NEW
OSMV reimburses MSP

Instructions

Steps 1 – 3 have not changed

- This is the current process.

Step 4A has not changed

- Commercial drivers or drivers age 80+ who come in for a regularly scheduled visit pay the doctor for this service.
- This DME is yellow; there is no MSP fee code and no boxes for the PHN number.

Step 4B is new

- OSMV pays for drivers who have a medical condition.
- This DME is blue, has an MSP fee code and boxes for the driver's PHN.
- The doctor's office must ensure the PHN number is on the form and enter the MSP fee code into the billing system for payment.

Step 5 is new

- MSP sends payment to doctors as part of the regular bi-monthly remittance.

Office of the Superintendent (OSMV) Form Fee Items

Effective June 1, 2006 you may submit claims to MSP for payment of the following Office of the Superintendent of Motor Vehicles (OSMV) forms. However, if either the date of service or date the form was issued is prior to June 1, 2006 the claim will not be accepted.

96220-OSMV Driver's Medical Examination Report (DMER) for any driver with a known or possible medical condition $75.00

Notes:

i) Not billable in addition to fee item 96221
ii) This fee may only be claimed when specifically requested by the Superintendent of Motor Vehicles
iii) Patient birth date is required on the claims submission.
iv) Patient driver's licence number is required on the claims submission.
(Drivers license number must be entered in the first 7 spaces of the note or comment field)
v) A complete physical, office or counselling visit may not be claimed in addition if the patient is seen for the same condition.
vi) Repeat DMER is not payable to any practitioner within 3 months.
vii) No extra charge to the patient.

96221-OSMV Diabetic Driver Report-stand alone (no DMER): Diabetic Driver Report for commercial drivers with diabetes (known medical condition) $75.00

Notes:

i) Not billable in addition to fee item 96220
ii) This fee may only be claimed when specifically requested by the Superintendent of Motor Vehicles
iii) Patient birth date is required on the claims submission.
iv) Patient driver's licence number is required on the claims submission.
(Drivers license number must be entered in the first 7 spaces of the note or comment field)
v) A complete physical, office or counselling visit may not be claimed in addition if the patient is seen for the same condition.
vi) Only applicable to claims submitted under diagnostic code 250 (diabetes mellitus)
vii) Repeat Diabetic Driver Report-stand alone is not payable to any practitioner within 3 months.
viii) No extra charge to the patient.

96222- OSMV Diabetic Driver Report-sent out with DMER: Diabetic Driver Report for commercial drivers with diabetes (known medical condition) 30.00

Notes:

i) Fee item 96220 must also be billed on the same date of service.
ii) This fee may only be claimed when specifically requested by the Superintendent of Motor Vehicles.
iii) Patient birth date is required on the claims submission.
iv) Patient driver's licence number is required on the claims submission.
(Drivers license number must be entered in the first 7 spaces of the note or comment field)
v) A complete physical, office or counselling visit may not be claimed in addition if the patient is seen for the same condition.

vi) Only applicable to claims submitted under diagnostic code 250 (diabetes mellitus)
vii) Repeat Diabetic Driver report with DMER is not payable to any practitioner within 3 months
viii) No extra charge to the patient.

When submitting the OSMV form fees the drivers licence number must be entered in the first 7 spaces of the note or comment field.

If you have questions about the OSMV forms please call: 250 356-5964 (number available until September 1, 2006) - after September 2006 contact the phone number listed on the forms.

For billing questions: contact HIBC/Claims Billing Support:

Vancouver	604 456-6950
Toll Free	1 866 456-6950

BRITISH COLUMBIA Ministry of Health Services

Update to the Medical Services Commission
Payment Schedule

Preamble

The following modifications to the Payment Schedule have been approved effective immediately:
(*Minute of the Commission signed January 16, 2006*)

Amendment

The following wording is added subsequent to the current wording under Section B.18 – Salaried and Sessional Arrangements:

Other Agencies

With the exception of physicians paid by the BC Transplant Society under an Alternate Payment Plan, all physician services associated with cadaveric organ donor recovery ("organ donation") are payable on a fee-for-service basis through the Medical Services Plan. For the purpose of payment of these services, the donor's PHN will remain valid after legal brain death until such time as the donor's organs have been successfully harvested. A note record should accompany the account stating "organ donor".

General Services

The following modifications to the Payment Schedule have been approved effective immediately:
(Minute of the Commission signed January 12, 2006)

Amendment – Tray Fees

1. The following fee item is to be added to the list of fee items eligible for a major tray fee (00090)

04111	Therapeutic abortion (vaginal) by whatever means – less than 14 weeks gestation (operation only)

2. The following note is to be added to fee item 00090 (major tray fee):
Note: Applicable to 04111 only when rendered in private (non-funded) facilities. Not applicable when rendered in hospital or other publicly-funded facilities.

General Practice

The cancellation dates of the following provisional items have been extended. This Minute will expire on January 31, 2007 or when replaced by a subsequent Minute, whichever occurs first:

P13020 Telehealth General Practitioner Assistant - Physical Assessment as requested by receiving specialist: - for each 15 minutes or major portion thereof 27.90

Notes:

i) Applicable only if general practitioner is required at the referring end to assist with essential physical assessment, without which the specialist service would be ineffective.

ii) Applies only to period spent during consultation with specialist.

Dermatology

Amendment

The cancellation date of the following provisional item has been extended. It expires on December 31, 2006 or when replaced by a subsequent Minute, whichever occurs first:

P00228 Photo-epilation of facial hair – per ¼ hour (or major portion thereof) $27.88

Notes:

i) Billable to a maximum of ½ hour per session

ii) Epilation of facial hair for familial hirsutism is not a benefit of the Plan

iii) Pre-authorization is required (see Preamble B.16.2.(6))

The cancellation dates of the following provisional items have been extended. This Minute will expire on January 31, 2007 or when replaced by a subsequent Minute, whichever occurs first:

P20210 Telehealth Consultation: To include history and dermatological examination, with review of any previous X-ray and laboratory findings and written report $52.95

P20214 Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee (laboratory test and biopsy when necessary, extra) $36.15

***Note**: Punch and shave biopsies are included in consultation or visit fees.*

P20207 Telehealth subsequent office visit $21.89

P20208 Telehealth subsequent hospital visit $20.87

Ophthalmology

Amendment:

The cancellation date of the following provisional item has been extended. It will expire on December 31, 2006 or when replaced by a subsequent Minute, whichever occurs first.

P22125	Photodynamic therapy for age-related wet macular degeneration - professional fee *Note: Payable to Retinal Physicians certified in PDT treatment only.*	$274.39

The cancellation dates of the following provisional items have been extended. This Minute will expire on January 31, 2007 or when replaced by a subsequent Minute, whichever occurs first:

P22010	Telehealth Consultation: To include history, eye examination, measurement for refractive error, ophthalmoscopy, biomicroscopy, tonometry, eye-balance test, keratometry,where indicated and necessary to prepare a written report	$71.37
P22011	Telehealth repeat or limited consultation: To apply where a consultation is repeated for same condition within six months of the last visit to the consultant, or where in the judgment of full consultative fee	$47.89
P22007	Telehealth subsequent office visit	$27.58
P22008	Telehealth subsequent hospital visit	$21.72

Otolaryngology

Amendments:

1. The payment rates of the following fee items are adjusted as indicated, effective January 1, 2006. These amendments are funded by an across-the-board reduction in Otolaryngology surgical fee items as indicated on the following pages. These items are to be monitored for the 12-month period following the implementation date:

02262	Translabyrinthine approach for neurosurgical access exposure, closure with microscope	$1848.77
02512	Special consultation for dizziness: To apply where a patient has been referred by an Otolaryngologist or a Neurologist or a Neurosurgeon and to include all special examinations and an appropriate neurological assessment and a written report	$145.47
02610	Middle cranial fossa approach without petrosectomy – for trauma, neoplasm resection, nerve section/decompression ***Notes:*** *i) Includes exposure, removal and closure with microscope.* *ii) May include extra-dural resection of lesion by Otolaryngologist.*	$1376.51

2. The description of the following listing is hereby modified and notes added as indicated, effective January 1, 2006:

02333 Lateral rhinotomy and/or medial maxillectomy for excision of nasal tumor

Notes:

i) To include open or endoscopic techniques
ii) Not payable for polyps.

New Fee Items:

3. The following new fee items are funded from the new fee money identified in the Letter of Agreement and will be monitored for the 12 month period following the effective date of January 1, 2006:

25300 Endoscopic resection of intranasal or sinus tumor
- up to 7 hours operating time — $1000.00 Anes. Level 6

25301 - additional payment after 7 hours operating time — $250.00

Notes:

i) Fee items 25300 and 25301 are payable only when pre-operative radiological imaging indicates either distorted anatomy of the sinuses secondary to disease or injury, or revised complex anatomy resulting from prior surgery, such that without stereotactic guidance, the surgery could not be performed.
ii) Not payable for ethmoid disease, polypectomy or tumors affecting only one sinus.
iii) Includes all surgery necessary to access tumor
iv) Payable only when rendered in acute-care facility.
v) Time over seven hours is payable under fee item 25301
vi) Minimum of 3 hours surgery duration required to bill fee item 25300
vii) A written report must be submitted with claims billed under these items.

25305 Endoscopic ligation – sphenopalatine artery — $400.00 Anes. Level 6

Notes:

i) Not payable in addition to fee item 02335.
ii) Includes diagnostic endoscopy performed on same day as surgery.
iii) Not payable in addition to endoscopic tumor excision surgery.

25310 Endoscopic trans-nasal repair of CSF leak from anterior skull base — $932.82 Anes. Level 8

Notes:

i) Includes harvest of any tissue needed for the repair, including closure of any donor site.
ii) Includes complete sphenoethmoidectomy or frontal sinusotomy or sinus trephine if required.
iii) Iatrogenic injuries payable at 50%.

25315 Primary frontal sinusotomy — $222.00 Anes Level 3

Notes:

i) Requires direct visualization of frontal sinus recess/ostium
ii) Not to be billed in uncomplicated anterior ethmoidotomy
iii) Frontal sinus disease must be present to bill this item.
iv) Payable at 100% with fee items 02360, 02361, 02362 or 02363.

Otolaryngology Surgical Items Reduction

The payment rate of the following items, owned by the Section of Otolaryngology, will be reduced by 0.233%, as indicated:

Fee Code	Description	Current rate:	Revised rate:
02206	Removal of ear canal osteoma (operation only)	79.37	79.19
02209	Removal of obstructing exostosis of the ear canal	463.98	462.90
02210	Paracentesis of the ear drum (operation only)	42.73	42.63
02221	Microscopic debridement, foreign body removal, or aural polyp removal - with local anesthesia	25.95	25.89
02223	- under general anesthesia	61.04	60.90
02233	Transmastoid facial nerve decompression - vertical and horizontal segment	1,079.38	1,076.87
02234	- vertical segment	561.68	560.37
02224	Transcanal labyrinthotomy transmastoid for posterior semicircular canal occlusion.	209.49	209.00
02241	Labyrinthectomy - drill out of petrous bone	549.45	548.17
02242	Microsurgical repair and reconstruction soft tissue atresia, external ear canal – complete	761.91	760.14
02243	Repair atresia external ear canal, complete, bony .	1,013.43	1,011.07
02244	Repair stenosis external ear canal, bony	586.08	584.72
02245	Microsurgical repair and reconstruction soft tissue stenosis - external ear canal	634.92	633.44
02231	Microsurgical revision and reconstruction, soft tissue stenosis - external ear	507.93	506.75
02247	Mastoidectomy - partial, canal wall up (Cortical)	586.08	584.72
02248	Radical mastoidectomy	744.80	743.07
02249	Stapes-reconstruction	586.08	584.72
02250	- mobilization of	341.87	341.07
02246	- reconstruction with laser	634.92	633.44
02251	Myringoplasty repair of drum - without exploration of middle ear	183.15	182.72
02239	Tympanotomy - with ossicular chain reconstruction	341.87	341.07
02252	Tympanoplasty - without ossicular chain reconstruction (repair of ear drum as well as inspection of middle ear by means of a tympanotomy)	427.35	426.36
02264	- with ossicular chain reconstruction	647.14	645.63
02276	- lateral graft, homograft tympanic membrane	647.14	645.63
02253	Tympanomastoidectomy - Complete, canal wall down, including tympanoplasty	989.02	986.72
02265	- partial, canal wall down (atticotomy)	586.08	584.72
02263	Trans-tympanic polyneurectomy	317.45	316.71
02254	Myringotomy with insertion of aerating tube (operation only) - unilateral	79.37	79.19
02274	- bilateral	122.10	121.82
02255	Exploratory tympanotomy	225.90	225.37
02261	- with chemical control, tac procedure, cryosurgical control, ultrasound	372.41	371.54
02266	Myringoplasty - paper patch or synthetic	42.73	42.63
02256	Endolymphatic shunt, any procedure	830.27	828.34
02259	Excision of glomus - by tympanotomy approach	647.14	645.63
02260	- where extensive dissection is required	838.58	836.63

02269	Implantable bone conductor	449.54	448.49
02267	Conchal cartilage graft	305.24	304.53
02268	Intra-cochlear implant	927.97	925.81
02270	Transmastoid - posterior semicircular canal occlusion	761.91	760.14
02271	Transmastoid microsurgical removal of facial neuroma via extended facial recess approach	1,904.76	1,900.33
02272	Transmastoid microsurgical removal of middle ear/mastoid tumour.	1,142.86	1,140.20
02273	Microsurgical tympanomastoidectomy - complete, canal wall up.	1,079.38	1,076.87
02301	Removal of foreign body from nose - complicated with anesthetic	61.04	60.90
02303	Cauterization of Septum - electric	36.63	36.54
	Cryosurgical treatment of turbinates:		
02298	- unilateral	146.51	146.17
02299	- bilateral	183.15	182.72
02304	Turbinectomy - unilateral	91.56	91.35
02305	- bilateral	134.30	133.99
02306	Submucous resection of septum	158.72	158.35
02307	Naso-antral window - single	109.89	109.63
02308	- double	170.94	170.54
02309	Radical antrostomy	305.24	304.53
02310	- with closure of alveolar fistula	439.56	438.54
02360	Intranasal ethmoidotomy to include polypectomy, posterior - unilateral	341.87	341.07
02361	- bilateral	525.04	523.82
02362	Intranasal ethmoidotomy, anterior - unilateral	183.15	182.72
02363	- bilateral	305.24	304.53
02357	Endoscopic sinus surgery: Functional endoscopic sinus surgery in children under 14 years of age	305.26	384.55
02315	External radical fronto-ethmoidectomy	561.68	560.37
	Electrocoagulation of turbinates:		
02317	- one side	48.83	48.72
02318	- both sides	73.25	73.08
02319	Trephining frontal sinus	244.20	243.63
02321	Sinus sphenoidotomy (intranasal)	256.43	255.83
	Removal of nasal polypi:		
02322	- unilateral	97.69	97.46
02323	- bilateral	158.72	158.35
02324	Antral lavage - unilateral	32.13	32.06
02325	- bilateral	48.20	48.09
	Choanal atresia, definitive repair of:		
02326	- unilateral	463.98	462.90
02327	- bilateral	647.14	645.63
	Choanal atresia; perforation of:		
02328	- unilateral	158.72	158.35
02329	- bilateral	219.77	219.26
02336	Laser revision of choanal stenosis	126.99	126.69
	Submucous turbinectomy:		
02330	- unilateral	158.72	158.35
02331	- bilateral	244.20	243.63

	Lateral rhinotomy and excision tumour:		
02332	- benign	561.68	560.37
02333	- malignant	598.29	596.90
02334	Transantral ethmoidectomy	463.98	462.90
02335	Transantral ligation, internal maxillary artery	488.41	487.27
02337	Ligation of anterior and posterior ethmoid arteries	305.24	304.53
02338	Removal of angiofibroma-nasal pharynx	708.17	706.52
02342	Maxillectomy with exenteration of ethmoid	769.23	767.44
02339	Palatal fenestration	246.76	246.19
02343	Septal reconstruction	366.30	365.45
02341	Posterior nasal packing - to include balloon control of epistaxis (operation only)	61.04	60.90
02346	- with trans-oral gauze pack, under local, topical, or general anesthesia (operation only)	95.23	95.01
02345	Drainage of abscess or haematoma of septum (operation only)	109.89	109.63
02347	External osteoplastic frontal flap operation	891.35	889.28
02364	Nasal fracture - simple reduction	61.04	60.90
02365	- reduction and splinting	122.10	121.82
02348	Operative closure of oral-nasal fistula	341.87	341.07
02349	Operative closure of nasal septal perforation	488.41	487.27
02358	Revision endoscopic frontal sinusotomy, with or without C arm	444.44	443.41
02359	Revision endoscopic intranasal spheno-ethmoidotomy (anterior, middle and posterior cells including sphenoid)	507.93	506.75
02351	Nasal refracture requiring lateral osteotomies	341.87	341.07
02352	Reconstruction of nasal tip, ala, and columella	402.93	401.99
02353	External reconstruction of nasal tip, ala and columella (such as for cleft lip or open trauma).	539.69	538.43
02354	Complete rhinoplasty with S.M.R. to include nasal hump removal, nasal refracture, and reconstruction of nasal tip, without skin grafting	586.08	584.72
02355	Complete rhinoplasty with SMR to include nasal hump removal, nasal refracture and **external** reconstruction of nasal tip without skin grafting.	742.87	741.14
	Incision of peritonsillar abscess:		
02447	- under local anesthetic	48.83	48.72
02444	- under general anesthetic	123.28	122.99
	Tonsillectomy:		
02403	- under local anesthesia	246.64	246.07
02445	- adult or child over the age of 14 years	183.15	182.72
02446	- child age 14 years and under (to include neonate)	170.94	170.54
02413	Operative control of post-tonsillectomy or post-adenoidectomy haemorrhage requiring local or general anesthetic	158.72	158.35
02399	Cryotherapy of tonsils and oral lesions	109.89	109.63
02442	Adenoidectomy - adult or child over 14 years	123.28	122.99
02443	- child 14 years and under (neonate included)	151.42	151.07
02448	Retropharyngeal abscess - drainage under local anesthetic	122.10	121.82
02406	- requiring lateral pharyngotomy	231.98	231.44
02408	Removal of tumour from larynx or trachea	183.15	182.72
02409	Uvulo-palato-pharyngoplasty for obstructive sleep apnea confirmed by polysomnogram, with or without tonsillectomy	402.93	401.99

02410	Thyrotomy (including cordectomy)	488.41	487.27
02431	Hemilaryngectomy	1,385.49	1,382.27
02432	Supraglottic laryngectomy	1,507.72	1,504.21
02433	Vocal cord implant - injection	305.24	304.53
02434	- external approach	610.51	609.09
02414	Repair laryngo-tracheal stenosis - to include skin grafting, stenting, and associated endoscopy	1,379.73	1,376.52
02449	Rigid oesophagoscopy for removal of foreign body	183.15	182.72
02450	Bronchoscopy or microlaryngoscopy with removal of foreign body	244.20	243.63
02422	- in a child under the age of 3 years	364.26	363.41
02418	Repair of fractured larynx – external approach	793.65	791.80
02420	Dilation of trachea	79.37	79.19
02421	- repeat within one month	36.63	36.54
02425	Arytenoidectomy	610.51	609.09
02437	Transphenoidal removal of pituitary tumour or hypophysectomy - two surgeons - otolaryngologist	586.08	584.72
02438	Trans-oral cricopharyngeal myotomy	402.93	401.99
02424	Tracheoesophageal puncture and insertion of voice prosthesis following laryngectomy	341.87	341.07
02440	Bilateral micro-transposition of submandibular salivary ducts when done with or without a microscope.	323.82	323.07
02441	O.R. standby fee for the ENT surgeon in the operating room for management of acute airway obstruction (for example, epiglottitis, allergic laryngeal edema, malignancy).	285.71	285.05
02451	Excision of congenital cyst or fistula from neck	402.93	401.99
02452	Sialolithotomy - simple, in duct	61.04	60.90
02453	- complicated, in gland	183.15	182.72
02454	Alveolectomy	183.15	182.72
02455	Excision of submandibular gland	305.24	304.53
02456	Salivary fistula - plastic to Stensen's duct	402.93	401.99
02457	Tongue tie - under general anesthetic	79.37	79.19
02458	Local excision tongue - under general anesthetic	158.72	158.35
02459	Excision cystic hygroma	525.04	523.82
02412	Biopsy of larynx and/or cauterization (including laryngoscopy)	122.10	121.82
02419	Direct or indirect laryngoscopy with foreign body removal	146.51	146.17
02423	Micro-laryngoscopy - with removal of non-pedunculated malignancy or extensive submucosal lesion	426.33	425.34
02428	Micro-laryngoscopy - with biopsy of larynx and/or cauterization	170.94	170.54
02429	Micro-laryngoscopy and removal of tumour from larynx or trachea	195.36	194.91
	Microsurgery with use of carbon dioxide laser for removal of tumour(s) of larynx or trachea:		
02430	- first procedure	426.33	425.34
02435	- subsequent procedure, each	426.33	425.34
02612	Middle cranial fossa approach – petrosectomy	1,846.98	1,842.68
02613	Middle cranial fossa approach – petrosectomy - procedure lasting longer than 8 hours.	2,308.59	2,303.22
02614	Retrolabyrinthine approach for neurosurgical access - exposure, closure with microscope	1,154.27	1,151.58
02618	Repair of CSF leak following skull base approach with mastoid obliteration - to include exposure, dissection and closure with microscope	923.82	921.67

02622	Infra-temporal fossa approach to skull base - Otolaryngology fee.	1,846.98	1,842.68
02623	Infra-temporal fossa approach to skull base - Otolaryngology fee for procedure lasting longer than 8 hours.	2,308.59	2,303.22
02279	Resection base of tongue and/or tonsil and soft palate	1,843.74	1,839.45
02281	Conservative radical neck dissection	1,201.38	1,198.59
02470	Radical neck dissection	1,010.96	1,008.61
02471	Subtotal parotidectomy - with complete facial nerve dissection	805.88	804.01
02472	Total parotidectomy - with nerve dissection for malignancy or deep lobe tumour	927.97	925.81
02407	Tracheostomy	280.84	280.19
02411	Laryngectomy total	1,263.25	1,260.31
02473	Laryngo-pharyngo-oesophagectomy - primary excision only	1,516.44	1,512.91
02476	Pharyngoesophageal anastomosis - re-establishment in neck by neck surgeon	610.51	609.09
02474	Transoral maxillectomy with skin graft	1,010.93	1,008.58
02282	Composite resection of tongue, mandible, radical neck dissection and tracheostomy	1,843.74	1,839.45
02477	Contralateral suprahyoid dissection	463.98	462.90
02600	Complete temporal bone resection, ENT fee	2,308.82	2,303.45
02601	Temporal bone resection for neoplasm, subtotal and lateral, to include mastoidectomy and excision of external auditory canal	1,154.40	1,151.71
02275	Glossectomy - subtotal with either division of mandible or transcervical resection	1,010.90	1,008.55
02280	Otolaryngological component of cranio facial resection for tumour of ethmoid or frontal sinus or orbit (in conjunction with a neurosurgeon)	2,308.82	2,303.45
02478	Glossectomy - partial for carcinoma	354.09	353.27
02479	Transpalatal maxillectomy, ethmoidectomy, and sphenoidectomy	1,263.60	1,260.66
02480	Resection mandible, floor of mouth suprahyoid dissection and tracheostomy - malignancy	1,263.60	1,260.66

Internal Medicine

Amendment

The cancellation dates of the following provisional items have been extended. This Minute will expire on December 31, 2006 or when replaced by a subsequent Minute, whichever occurs first:

Patient Activated Cardiac Event Recorders

P00362	Event/unmonitored loop recorders (first strip) – professional fee	$35.52
P00369	- each additional strip (per strip) *Note: Additional strips are limited to two extra strips per patient, per two-week period.*	$17.76
P00392	Event/unmonitored look recorder – Technical fee	$42.68

Notes:

i) The following notes apply to fee items 00362, 00369, 00392

ii) These items are intended to cover a two-week period
iii) Consultation not paid in addition
iv) Provide note record when more than one recording billed per patient, per year
v) Holter monitor not payable in addition
vi) An explanatory note is required for second test, same patient.

Effective March 1, 2006, the following modifications to the payment schedule have been approved:

New Fee Items

P10735 Rectal endoscopy utilizing ultrasound (radial/linear) $150.00
Note: Includes mucosal biopsy.

P10740 Upper GI endoscopy utilizing radial ultrasound $250.00

P10741 Upper GI endoscopy utilizing linear ultrasound $250.00
Notes:
i) P10740 and P10741 are payable only when done in publicly funded acute care facilities
ii) P10741 payable at 50% when done subsequent to P10740 (same patient/same day)

P10742 Upper GI endoscopy utilizing radial/linear ultrasound – with biopsy using fine needle aspiration, to a maximum of 3 – per lesion $50.00
Notes:
i) Payable with P10740 or P10741 only
ii) 2nd and 3rd biopsy payable at 50%

P10743 Upper GI endoscopy utilizing radial/linear ultrasound – with injection of one or more of any of the following – metastases, nodes, masses or celiac plexus – extra $150.00
Note: Payable with P10740 and P10741 only.

P10744 Upper GI endoscopy utilizing radial/linear ultrasound – with drainage of pseudocyst (including stent insertion performed) – extra $200.00
Note: Payable with P10740 and P10741 only.

Rheumatology

P31110 Telehealth Consultation: To consist of examination, review of history, laboratory, x-ray findings and additional visits necessary to render a written report. $144.34

P31112 Telehealth Repeat or Limited Consultation: Where a consultation for same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant, the consultative services do not warrant a full consultative fee. $72.62

P31106 Telehealth directive care $40.00

P31107 Telehealth subsequent office visit $44.99

P31108 Telehealth subsequent hospital visit $29.10

Pediatrics

The cancellation dates of the following provisional items have been extended. This Minute will expire on January 31, 2007 or when replaced by a subsequent Minute, whichever occurs first:

P50510 Telehealth Consultation: To consist of an examination, review of medical history, laboratory, x-ray findings and additional visits necessary to render a written report $158.25

P50511 Telehealth Consultation for complex behavioural, developmental or psychiatric condition in a child: To consist of a physical and neurological examination, review of history, laboratory, x-ray findings and additional visits necessary to render a written report $320.65

Notes:

i) Not to be billed when no change in condition from previous assessment.

ii) Minimum time required for service is 1.5 hours.

iii) Developmental delays include, but are not limited to: non-verbal learning disability, developmental reading disability, developmental coordination disability, developmental writing disability, dyscalculia, autistic spectrum disorders, fetal alcohol syndrome, mental retardation and other cognitive defects.

iv) Includes collection of data from collateral sources and formal screening, as appropriate.

P50512 Telehealth repeat or limited consultation: Where a formal consultation for the same illness is repeated within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee $76.75

P50514 Telehealth prolonged visit for counselling $59.36
Note: The Plan will pay up to four such visits per year (see Clause B.4.c of the Preamble)

P50506 Telehealth directive care $38.23

P50507 Telehealth subsequent office visit $48.86

P50508 Telehealth subsequent hospital visit $38.64

Psychiatry

P60610 Telehealth individual full consultation: Diagnostic interview or examination, including history, mental status exam, and treatment recommendation, with written report $185.95

P60613 Telehealth Geriatric consultation (patients 75 years or older) $256.46

P60622 Telehealth consultation – Emotionally disturbed child: Diagnostic interview or examination, including mental status and treatment recommendation, assessment of parents, guardian, or other relatives and written report $320.65

P60625 Telehealth – Individual consultation $93.91

P60614 Telehealth – Geriatric consultation $128.21

P60626 Telehealth – Emotionally disturbed child $160.33

P60607 Telehealth office visit to include services such as chemotherapy management and/or minimal psychotherapy $39.75

P60608 Telehealth hospital in-hospital visit $46.62

Individual Telehealth Psychiatric Treatment:

P60630	- per ½ hour	$79.46
P60631	- per ¾ hour	$110.74
P60632	- per 1 hour	$141.81

Family/Cojoint Telehealth Therapy – (two or more family members)

P60633	- per ½ hour	$84.68
P60635	- per ¾ hour	$118.01
P60636	- per 1 hour	$151.19
P60624	Evaluation interview with family member without presence of patient – per ½ hour session	$72.99
P60645	Patient Management Conference – meeting by specific appointment to discuss/plan patient management with third parties, which may include referring physicians or hospital staff (if an inpatient) or relatives and must include at least one professional or community agency representative – per ¼ hour	$39.75

Notes:

i) Not to exceed a maximum of two hours per patient per psychiatrist per calendar year.

ii) A written report of the meeting must be maintained and/or a report generated by the psychiatrist.

iii) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.

Plastic Surgery

P66010	Telehealth Major Consultation: To include complete history and physical examination, review of x-ray and laboratory findings, if required, and a written report	$64.73
P66012	Telehealth repeat or limited consultation: To apply where a consultation is repeated for the same condition within six (6) months of the last visit by the consultant or where in the judgment of the consultant the consultative service does not warrant a full consultative fee.	$35.58
P66007	Telehealth subsequent office visit	$21.45
P66008	Telehealth subsequent hospital visit	$18.28

The cancellation dates of the following provisional items have been extended, they will expire on March 31, 2007 or when replaced by a subsequent date, whichever occurs first:

PC61158	Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving major muscles	$746.48 Anes Level 5

Note: The following muscle flaps are payable under this item:

i) biceps femoris flap
ii) deltoid flap
iii) external oblique flap
iv) gastroocnemius flap
v) gluteus maximus flap
vi) gracilis flap
vii) latissimus dorsi flap
viii) pectoralis major flap

ix) rectus abdominus flap
x) rectus femoris flap
xi) soleus flap
xii) trapezius flap
xiii) temporalis flap
xiv) tensor fascia lata flap
xv) triceps flap
xvi) vastus lateralis flap
xvii) vastus medialis flap

PC61157 Myocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving medium muscles $560.08 Anes Level 5

Note: The following muscle flaps are payable under this item:
i) brachioradialis flap
ii) coracobrachialis flap
iii) pectoralis minor flap
iv) peroneus brevis flap
v) peroneus longus flap
vi) platysma flap
vii) sartorius flap
viii) serratus flap
ix) sternocleidomastoid flap
x) tibialis anterior flap
xi) tongue flap

PC61156 Mocutaneous flap or fascia cutaneous flap rotated on its vascular or neurovascular pedicle involving small muscles $373.39 Anes Level 5

Note: The following muscle flaps are payable under this item:
i) abductor digiti minimi flap
ii) abductor hallucis flap
iii) abductor pollicis brevis flap
iv) anconeus flap
v) extensor digitorum communis flap
vi) extensor digitorum longus flap
vii) extensor hallucis longus flap
viii) first dorsal interosseous flap
ix) flexor carpi ulnaris flap
x) flexor digitorum brevis flap
xi) flexor digitorum longus flap
xii) flexor hallucis longus flap
xiii) orbicularis oculi flap
xiv) orbicularis oris flap

The cancellation dates of the following provisional items have been extended until October 15, 2006:

CP06159 TRAM Flap reconstruction of mastectomy defect $1,000.00 Anes.Level 5

Notes:
i) Includes preparation of site to be grafted, harvesting or insertion of the graft, closure of donor defect, with or without mesh.
ii) Reconstruction of both breasts (bilateral) with two pedicled TRAM flaps is payable at 150%.

P61152	Abdominal panniculectomy – where medically indicated, secondary to chronic subpanus intertrigo, which has been unresponsive to a reasonable period of medical treatment *Note: To include umbilicoplasty where medically indicated.*	$292.68 Anes.Level 4
P61166	Mastopexy, balancing unilateral (isolated procedure)	$313.79 Anes.Level 3
P61167	Mastopexy, balancing – when performed at same time as contralateral breast surgery	$235.34 Anes.Level 3
P61223	ORIF of phalangeal (middle or proximal) or metacarpal fracture	$261.00 Anes.Level 2
P61222	CRIF of phalangeal (middle or proximal) or metacarpal fracture	$191.35 Anes.Level 2

General Surgery

Amendment

The cancellation date of the following provisional items have been extended. This will expire on May 31, 2007 or when replaced by a subsequent Minute, whichever occurs first:

P07479	Sentinel lymph node biopsy (SLN)	$433.96 Anes.Level 3

Notes:

i) Payable only for the staging of malignant breast disease and malignant melanoma.
ii) Subsequent surgery (07474 or 07475) performed under same anesthetic is payable at 50% of the applicable fee of the lesser item.
iii) Payable only to BCCA validated physicians.
iv) SLN component of the combined procedure not payable to surgeons during the training phase.

Thoracic (Chest) Surgery

P79210	Telehealth Consultation: To include complete history and physical examination, review of x-ray and laboratory findings an a written report	$114.41
P79212	Telehealth Repeat or Limited Consultation: To apply where a consultation is repeated for the same condition, within six months of the last visit by the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee	$51.49
P79207	Telehealth subsequent office visit	$22.83
P79208	Telehealth subsequent hospital visit	$19.48

Radiology

Amendment:

The notes subsequent to the following the Bone Mineral Densitometry listings are hereby modified as indicated:

T08688 Bone density - single area
T08689 Bone density - second area
T08696 Bone density - whole body

Notes:

i) Please refer to revised Guideline "Bone Density Measurement in Women" to determine if service is payable by MSP. Claims for males and females <50 require written explanation indicating risk factor.

ii) Altering patient care requires one of the following:
- *a. prescribing bisphosphonates (ie: fosomax)*
- *b. weaning patient off glucocorticosteriods (ie: prednisone)*
- *c. adequate ongoing monitoring (in cases of primary hyperparathyroidism)*

iii) Not payable for following indications:
- *a. chronic back pain*
- *b. kyphosis*
- *c. menopause*
- *d. patients prescribed depoprovera*
- *e. Routine bone density screening*

iv) Additional areas paid to a maximum of one, except for unusual circumstances, which must be accompanied by written explanation.

v) Repeat scans are not billable within two years of a previous scan, except for indications outlined in the guidelines, which must be accompanied by written explanation.

vi) Claims for whole body bone density must be accompanied by written explanation of need.

vii) Includes any lumbar and/or hip radiographs taken as a part of the procedure. Medically necessary lumbar and or hip radiographs for other disease processes may be billed when accompanied by written explanation.

viii) Restricted to certified radiologists or nuclear medicine physicians and individuals who have received approval from Diagnostic Accreditation Program (DAP) to perform these tests, and the tests are provided in a DAP accredited and MSC approved facility.

The cancellation date of the following provisional item has been extended – this Minute will expire on May 31, 2007 or when replaced by a subsequent Minute, whichever occurs first:

P83000 Interventional Radiology Consultation – to include pertinent patient history, regional physical examination, review of laboratory and radiological findings and generation of written report $75.00

Notes:

i) Payable only to physicians with appropriate training in interventional radiology

ii) Payable only when rendered in acute care public facilities.

iii) Must be initiated by written request by another physician

iv) Payable only when interventional radiological procedure requires extensive discussion and review of all available data.

v) Includes all patient visits necessary

vi) Payable only when patient is recommended for one of the following interventional therapeutic radiological procedures:
- *a. Percutaneous image-guided catheter directed thrombolysis of peripheral vein/artery (10901)*

b. *Varicocele and/or uterine artery embolization – unilateral/bilateral (00921/00925)*
c. *Percutaneous image-guided tumor ablation*
d. *Percutaneous transcatheter arterial chemoembolization (TACE)*

vii) *Payable with the following procedures only when the definitive procedure is cancelled subsequent to the consultation:*
a. *Percutaneous nephrostomy (00978)*
b. *Percutaneous nephrostomy with dilation of tract (00979)*
c. *Transhepatic biliary drainage procedure (00980)*
d. *Therapeutic radiological embolization (00981)*
e. *Percutaneous transluminal angioplasty (00982)*
f. *Percutaneous abdominal abscess drainage by catheter insertion (00983)*
g. *Embolization fee codes T00995, T00997, T00998;*
h. *Abdominal aortic aneurysm repair using endovascular stent graft – radiology component (P10900)*
i. *Complex diagnostic neuroangiography*

viii) *Repeat consultation not applicable for same condition, same patient within 6 months.*

The cancellation dates of the following provisional items have been extended. This Minute will expire on May 31, 2007 or when replaced by a subsequent Minute, whichever occurs first:

P10901 Percutaneous image-guided catheter directed thrombolysis of peripheral vein/artery
$525.00
Anes. Level 2

Notes:
i) *Includes any medically necessary angiographies, any necessary imaging, all necessary catheter repositioning and ongoing assessment and care throughout the patient's active treatment phase.*
ii) *Payable at 100% for the first 12 hours of care and 50% for each additional 12 hours of care, up to 36 hours.*

P10902 Peripherally inserted image-guided central venous catheter line (PICC)
$100.00
Anes.Level 2

Notes:
i) *Interventional Radiology consultation not payable in addition, regardless of when rendered.*
ii) *Not applicable if performed via other than peripheral access.*
iii) *Includes placement, venogram/angiogram, and all medically required image guidance*
iv) *May not be delegated*

P10903 Percutaneous hemodialysis graft thrombolysis $525.00
Anes. Level 2

Notes:
i) *Includes declotting and treatment of underlying cause of access failure*
ii) *Includes angioplasty and all necessary imaging and intervention*
iii) *Consultation not payable in addition, regardless of when rendered.*

The cancellation dates of the following provisional items have been extended. This Minute will expire May 31, 2007 or when replaced by a subsequent Minute whichever occurs first:

P10905 Cerebral intra-arterial thrombolysis $1,168.24

Notes:

i) Payable once only, regardless of number of arterial territories treated.

ii) Includes all diagnostic and superselective angiograms performed during procedure and immediate post procedure CT scans.

iii) Interventional radiology consultation not payable in addition.

P10906 Image-guided percutaneous vertebroplasty – first level $325.00

P10907 - each additional level (to a maximum of 3) $75.00

Notes:

i) Payable only when rendered on in-patient or day-care basis in acute care facility;

ii) Payable for osteoporotic fractures only if conservative therapy shows no or minimal improvement after 4-6 weeks and pain remains incapacitating;

iii) Includes all associated diagnostic imaging, including post procedural CT scan necessary to complete the procedure;

iv) Interventional Radiology consultation not payable in addition.

P10904 Percutaneous transcatheter arterial chemo-embolization (TACE) $325.00

Notes:

i) Fee is per session/sitting, regardless of number of lesions treated;

ii) Includes all associated imaging necessary to complete procedure;

iii) Interventional Radiology consultation is payable.

P10908 Percutaneous image-guided tumour ablation – first lesion $432.00

Notes:

i) Payable only for non-resectable liver, kidney, lung tumours, colorectal metastases and osteoid osteoma;

ii) Payable to a maximum of 3 lesions treated at same session – 100% for first lesion, 75% for second lesion and 25% for third lesion;

iii) Includes all CT and ultrasound guidance necessary to complete the procedure;

iv) Paid at 50% if repeated within 30 days;

v) Interventional Radiology consultation is payable.

P10909 Percutaneous intravascular/intracorporeal medical device/foreign body removal $350.00

Notes:

i) All angiography, angioplasty and/or intravascular stenting included;

ii) If a second or third medical device /foreign body is removed, payable at 50% each, to a total maximum of three;

iii) Interventional Radiology consultation is not payable.

P10911 Selective salpingography/fallopian tube recanalization (FTR) $350.00

Notes:

i) Hysterosalalpinogram not payable in conjunction with the procedure;

ii) Paid at 2/3 of the fee if unilateral;

iii) FTR is not an insured benefit when used to correct scarring of the fallopian tubes after reversal of tubal ligation;

iv) Any imaging related to the procedure is inclusive.

P10912 Transjugular liver/renal biopsy $350.00

Notes:

i) Ultrasound guidance, venous puncture, central access catheter are included in the fee;
ii) Payable only for uncorrectable coagulopathy;
iii) The first biopsy is payable at 100%, the second and third at 50% up to a maximum of three per patient per day;
iv) If repeated within 6 months, payable at 50%;

Interventional Radiology consultation not payable

Laboratory Medicine

The cancellation date of the following provisional item has been extended, it will expire on December 31, 2006 or when replaced by a subsequent Minute, whichever occurs first:

P92355	Troponin	$30.77
P92510	Methadone Metabolite	$4.33
P92513	Methadone	$4.33
P92515	Blood Methadone	$56.73
P91760***	Helicobacter pylori Carbon 13 urea breath test	$59.99
P91719	Glucose – 2 hr, post-75 g	$19.76
P92227	Sirolimus	$53.19

The cancellation dates of the following provisional items have been extended. This Minute will expire on December 31, 2006 or when replaced by a subsequent Minute, whichever occurs first:

Haematology:

P90027***	Activated Protein C Resistance (APCR)	$51.88
P90036**	Antiphosphatidylserine (IgG)	$30.03
P90037**	Antiphosphatidylserine (IgM)	$30.03
	Note: When both P90036 and P90037 performed on same specimen, second test is billable at $22.38.	
P90038***	Anti Saccharomyces Cerevisiae (ASCA) – IgA	$31.50
P90039***	Anti Saccharomyces Cerevisiae (ASCA) – IgG	$31.50
	Note: When both P90038 and P90039 are performed on same specimen, second test is billable at $25.11.	
P90042***	Anti-Xa Heparin assay	$115.01
P90045*	Bone marrow examination	$265.97
	Note: 90045 includes 90465, 90490, 90205, 90340 and 90210	
P90055***	Circulating inhibitor screen - unincubated simple mixing study	$37.32
P90065	Cold agglutinins – qualitative	$17.69
P90072**	Collagen Binding assay	$64.17
	Note: Not billable with 90505.	
P90073**	Dilute Russell Viper Venom Time	$31.33
P90075**	Differential cell count on body fluids other than blood	$12.72
90080	Direct antiglobulin (Coombs') test, polyspecific	$30.36
P90095**	Erythropoietin (EPO) assay	$36.08
P90127***	Factor V Leiden / PGM – 1st gene	$95.12

Notes:
i) Restricted to Royal Columbian, Vancouver and Victoria General Hospitals
ii) Not billable for screening purposes
iii) Applicable to patients with thrombophilia.

P90128***	Factor V Leiden / PGM – 2nd gene	$60.01
	Notes:	
	i) Billable only when performed with P90127	
	ii) Restricted to Royal Columbian, Vancouver and Victoria General Hospitals	
P90185	Glucose-6-phosphate dehydrogenase (G-6-PD) screening test	$21.35
P90240**	Haemoglobin electrophoresis	$38.60
P90290**	Immunophenotyping by flow cytometry - peripheral blood and/or tissue and/or bone marrow and/or body fluids - 5 tube panel	$266.23
P90335**	Malaria and other parasites	$23.20
P90340**	Marrow films for interpretation	$195.16
P90357	Neutrophil Oxidative Burst Assay	$137.83
P90360**	Nitro blue tetrazolium test	$37.21
P90377**	Phospholipid Neutralization Test – for confirmation of Lupus Anticoagulant	$52.25
P90390**	Platelet antibodies	$42.11
P90400	Platelet estimation on film	$5.67
P90427**	Protein S Activity (clot-based)	$46.82
	Note: Not billable with 90435 or 90430	
P90440	Prothrombin time/INR	$14.89
P90460+	RBC antibody detection, per tube (albumin, enzyme or other antibody enhancement, e.g. LISS additive)	$8.44
P90465	RBC morphology including platelet estimation	$8.44
P90470	Red cell folate	$39.74
P90510+	Saline tubes (per tube)	$9.28
P90525	Sickle cell identification	$30.90
P90530***	Stypven prothrombin time	$34.57
P90560***	Von Willebrand's multimer analysis by autoradiography	$108.49
P91160**	Antimyeloperoxidase Ab	$31.82
P91355	Cells, count - CSF and other fluids	$36.01

Microbiology:

P90605**	Anaerobic culture investigation	$14.55
P90610***	Smear for inclusion bodies	$40.23
P90615**	Antibiotic susceptibility test, semi-quantitative per organism	$19.24
P90620	Biochemical identification of micro-organism- per organism	$11.80
P90625**	Blood culture, using aerobic and/or anaerobic media	$42.99
P90651	Chlamydia trachomatis using NAT – urine	$32.99
P90652	Chlamydia trachomatis using NAT – urogenital swab	$32.06
P90665**	Fungus culture	$16.73
P90730	Smear for inclusion bodies	$15.05
P90740	Stained smear	$7.25
P90750	Biochemical identification of micro-organism in stool	$14.21
P90780**	Throat or nose culture - each additional culture	$6.18
P90785	Trichomonas and/or candida, direct examination	$5.49
P90795	Examination for pinworm ova	$5.76
P90815	Serological tests - 1 to 3 antigens	$31.23
P90820	Serological tests - 4 or more antigens	$46.41
	Note: Not to be billed for any virology testing where specific listings exist (e.g.: Hepatitis).	
P90825***	Smear or section for electron microscopy	$33.98
P90830	Virus isolation	$55.82
P91023**	Acetyl CoA: a-glucosaminide-N-acetyl transferase, white blood cells	$114.53
	Note: Restricted to BC Children's Hospital.	

P91027**	Acid Lipase, white blood cells *Note: Restricted to BC Children's Hospital.*	$62.64
P91036***	ACTH stimulation test	$53.27
P91037**	Acylcarnitine profiling *Note: Restricted to BC Children's Hospital.*	$50.45
P91096**	Alpha-iduronidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$62.64
P91097**	Alpha-mannosidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$62.64
P91120***	Amniotic fluid, bilirubin scan	$64.89
P91142**	Anti-diuretic hormone (ADH), plasma	$111.26
P91155*	Antiglomerular basement membrane antibody	$31.82
P91162	Anti-tissue transglutaminase antibodies (anti-TTG), IgA *Note: Not billable with 91800.*	$29.90
P91180***	Apoprotein E genotyping	$75.55
P91231**	Beta-glucuronidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$62.64
P91232**	Beta-mannosidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$62.64
P91330	Calculus analysis – urine	$34.45
P91380**	Cholinesterase with dibucaine number	$37.00
P91386***	Chromatography - keto acids	$44.38
P91387***	Chromatography - reducing substances-urine	$38.37
P91388***	Chromatography - thin layer (T.L.C.)	$39.91
P91395	Complement, total haemolytic (CH 100)	$54.04
P91480	Acetazolamide	$56.86
P91484	Amikacin	$56.86
P91486	Amiodarone	$56.86
P91490	Amoxapine	$56.86
P91492	Chlorpromazine	$56.86
P91496	Clobazam	$60.89
P91498	Clomipramine	$60.89
P91500	Clonazepam	$56.86
P91508	Desmethylclobazam	$56.86
P91510*	Diazepam	$56.86
P91512	Disopyramide	$56.86
P91514	Doxepin	$56.86
P91516	Fluoxetine	$56.86
P91518	Flupenthixol	$56.86
P91520	Fluphenazine	$56.86
P91522	Fluvoxamine	$56.86
P91526	Haloperidol	$56.86
P91528	Imipramine	$56.86
P91530	Lidocaine	$54.66
P91532*	Lorazepam	$56.86
P91534	Loxapine	$56.86
P91536	Maprotiline	$56.86
P91538	Methotrexate	$56.25
P91540	Methotrimeprazine	$56.86
P91542	Methylphenidate	$56.86
P91544	N-Acetyl procainamide	$56.86
P91546	Netilmicin	$56.86
P91548	Nitrazepam	$56.86
P91552	Paroxetine	$56.86
P91554	Perphenazine	$56.86
P91556	Procainamide	$56.86

P91558	Propranolol	$56.25
P91560*	Sertraline	$56.86
P91562	Thioridazine	$56.86
P91566	Trazodone	$56.86
P91568	Trifluoperazine	$56.86
P91570	Trimipramine	$56.86
P91601**	Electrophoresis - protein, quantitative	$33.25
P91602**	Electrophoresis - C.S.F	$38.59
P91680	Gastric analysis, intubation	$22.17
P91715***	Glucose quantitative, 2 to 5 hours	$36.65
P91717**	Glucose quantitative – intravenous	$47.54
P91730	Glutathione peroxidase	$52.20
P91762**	Heparan sulfamidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$114.53
P91777**	Hexosaminidase, white blood cells *Note: Restricted to BC Children's Hospital.*	$114.53
P91800	IgA Anti-gliadin antibodies *Note: Applicable only to TTG negative gluten sensitive enteropathy*	$39.83
P91820***	Immunofixation – CSF	$124.04
P91850	Inclusion bodies - (cytomegalic) – urine	$9.51
P91912	Lead - prophyrin screening test – urine	$7.60
P91915***	Lecithin sphingomyelin ratio	$273.52
P91920***	LHRH stimulation test - in addition to specific tests billed	$56.48
P91940**	Lipoprotein electrophoresis	$68.49
P91970	Metachromatic granules – urine	$18.34
P91992	Mitochondrial preparation – muscle *Note: Restricted to BC Children's Hospital.*	$110.67
P91997**	N-acetyl-Galactosamine-6-sulfate sulfatase, white blood cells *Note: Restricted to BC Children's Hospital.*	$114.53
P92035	Pentagastrin test – gastric	$82.50
P92075	Pigments, abnormal, (spectroscopic)	$17.18
P92090	Porphyrins - qualitative, urine	$9.43
P92091	Porphyrins - quantitative with separation – urine	$67.63
P92095**	Porphyrins - quantitative – blood	$26.92
P92110	Pregnancy Test – Serum	$10.14
P92146	Proteins - timed urine collection	$10.96
P92156**	Pyruvate Carboxylase, Fibroblasts *Note: Restricted to BC Children's Hospital.*	$114.53
P92157**	Pyruvate Dehydrogenase, fibroblasts *Note: Restricted to BC Children's Hospital.*	$114.53
P92195**	Respiratory chain enzymes – muscle *Notes:* *i) Includes Complex 1, Complex II, Complex IV, citrate synthase* *ii) Restricted to BC Children's Hospital.*	$335.53
P92201	Salicylates, qualitative – gastric	$3.54
P92202	Salicylates, qualitative – urine	$3.67
P92320***	Thyroid Releasing Hormone (TRH) Stimulation Test *Note: Includes all time spent with patient, including injection and medication administered.*	$68.33
P92346**	Transferrin Isoelectric focusing (qualitative) *Note: Restricted to BC Children's Hospital.*	$110.59
P92353**	13C Triolein Breath Test for malabsorption *Note:* *i) Includes collection of "before" and "after" breath samples* *ii) Not billable with 91636* *Note: Restricted to BC Children's Hospital.*	$82.97

P92395	Urinalysis, microscopic	$5.89
P92430*	Vitamin A	$56.38
P92435*	Vitamin B1	$66.36
P92440*	Vitamin B2	$66.36
P92445*	Vitamin B6	$66.36
P92465	Vitamin E	$63.53
P92467	White blood cell preparation for lysosomal enzyme testing	$51.76
P92470**	Xylose tolerance	$129.72

Anatomical:

P93010	Crystal identification, synovial fluid	$41.11
P93070***	Chromosomal breakage studies	$214.10
P93085	Cytologic preparation and examination of fine needle aspirate	$112.30
P93090	Cytologic preparation and interpretation of pre-screened, non-gynaecological cytology	$78.10
P93095	Cytologic preparation and interpretation of unscreened, non-gynaecological cytology	$101.90
P93100*	Electron microscopy fee	$458.06

Nuclear Medicine:

P09817	Receptor Imaging - Isolated Procedure	$235.77
P09826	Tumour imaging - isolated procedure	$1265.13
P09870	Ocular tumour localization	$164.92
P09871	Brain scan - regional cerebral blood flow (isolated procedure)	$239.95
P09880	Treatment for hyperthyroidism or cardiac disease - charge per course of treatment (Iodine therapy)	$205.41
P09881	Treatment for polycythaemia vera with P32 - charge per course of treatment	$205.41
P09883	Treatment for prostate cancer - charge per course of treatment	$414.88
P09884	Treatment for metastatic carcinoma of bone - charge per ourse of treatment	$269.74
P09885	Treatment for ascites and/or pleural effusion, malignant	$403.91
P09898	Coronary perfusion with radio particles, per radionuclide	$175.74

Medical Microbiology:

P94005	Emergency visit when specially called (not paid in addition to out-of-office-hours premiums)	$104.76
P94010	Consultation: to consist of examination, review of history and laboratory findings with a written report	$117.83
P94012	Repeat or limited consultation: where a consultation for same illness is repeated within six (6) months of the last visit by the consultant or where, in the judgement of the consultant, the consultative service does not warrant a full consultative fee	$65.47
P94006	Directive care	$26.19
P94007	Subsequent office visit	$26.19
P94008	Subsequent hospital visit	$26.19
P94009	Subsequent home visit	$52.43

Nuclear Medicine

Amendment:

Effective immediately, Section 7 of Preamble to the Nuclear Medicine Schedule is hereby amended by adding the following fee items to the list of items payable with fee item 09877 (repeat of major scan – no additional radionuclide):

09854	Thallium myocardial scan
95053	Thallium Body Imaging

Deleted Fee Items:

The following fee items are hereby deleted, effective February 28, 2006:

09862	Cardiac function studies, dynamic
95010	Cardiac stress ejection fraction

In addition, all references to the above-mentioned deleted fee items are also removed from the Fee Schedule. The notes pertaining to the following fee items are therefore modified as indicated:

95000 Cardiac first pass
Note: Not paid with 95005.

95005 Cardiac shunt
Note: Not paid with 95000.

95040 Radionuclide cardiac ventriculography – with stress
Notes:

i) Only one of the following items is payable when requested and rendered with a radionuclide cardiac ventriculography (gated study MUGA) – (fee items 09863, 95040)
   a. Cardiac first pass (fee item 95000), or
   b. Cardiac shunt (fee item 95005)

ii) 95040 includes 09863.

Full Service Family Practice Incentive Program

As part of the 2006 Working Agreement, the General Practice Services Committee (a joint committee of the B.C. Ministry of Health, the B.C. Medical Association, and the Society of General Practitioners of B.C.) has developed a number of initiatives in support of full service family practice.

For program details and eligibility criteria, please refer to the Full Service Family Practice *Frequently Asked Questions* document at:
http://www.health.gov.bc.ca/msp/legislation/bcmaagree_faqs_fsfp.html#faqas
Additional information:
http://www.bcma.org/public/CDM/CDMIncentivePaymentInfo.htm
or
http://www.health.gov.bc.ca/cdm/practitioners/index.html

Initiative Highlights

1. Eligibility
2. Expanded Full Service Family Practice Condition Based Payments
3. Family Physician Obstetrical Premium
4. One Time Incentive Payments
5. Maternity Care Network Initiative
6. Patient Management Conference Fee
7. Complex Patient Clinical Conference Fee
8. Table 1: Eligible Patients for Patient Conference Fees

1. Eligibility

Detailed eligibility criteria have been identified for each of the six initiatives. In general, you are eligible to participate in the incentive program if you are:

1. A general practitioner who has a valid BC Medical Service Plan practitioner number (registered specialty 00). Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.
2. Currently in general practice in BC as a full service family physician, and
3. Responsible for providing the patient's longitudinal general practice care.

The General Practice Services Committee is committed to the support of Full-Service Family Practice, a style of practice that includes most of the following:

- Health and health risk assessments
- Co-ordination of patient care across the spectrum of primary, secondary, and tertiary care, including making referrals and acting upon consultative advice
- Longitudinal care of patients across the spectrum of their medical needs
- Diagnosis and management of acute ailments
- Chronic Disease Management, including implementation of BC guidelines
- Primary reproductive care including the organization of appropriate screening
- The provision of or the arrangement with another provider for the provision of prenatal, obstetrical, postnatal, and newborn care
- Primary mental health care
- Primary palliative care

- Care and support of the frail elderly
- Support for hospital, home, rehabilitation and long-term care facilities
- Patient education and preventive care
- The maintenance of a longitudinal patient record
- An association with other practitioners that provides patients with a designated provider to contact for medical advice and/or care as appropriate both during and outside of office hours, an association that includes the use of call-group guidelines and protocols for patient follow-up
- The future use of Information Technology systems as they become available to further enhance the co-ordination and provision of patient care.

2. Expanded Full Service Family Practice Condition Based Payments

This incentive program is aimed at supporting high quality management of congestive heart failure, diabetes, and hypertension. Physicians will now receive an annual payment of $125 for each patient with diabetes and/or congestive heart failure whose clinical management is consistent with recommendations in the B.C. Clinical Practice Guidelines. In addition, an annual $50 incentive payment is now available for BC Clinical Practice Guidelines treatment of hypertension where this care is not part of in treating diabetes or congestive heart failure.

Fee Item Information

Fee item 13050 –incentive for full service GP-annual chronic care bonus (diabetes and congestive heart failure) will be retroactively cancelled on March 31, 2006 and replaced with the following fee items effective April 1, 2006:

14050 incentive for full service GP-annual chronic care bonus (diabetes)-$125.00

Notes:

i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.

ii) Payable to the general practice full service family physician who has provided the majority of the patients longitudinal general practice care over the preceding year and who has provided an adequate level of guideline based care.

iii) Applicable only for patients with confirmed diagnosis of diabetes mellitus

iv) Care provided must be consistent with the BC clinical guideline recommendations for diabetes mellitus and may only be billed after 2 columns of the flow sheet have been completed.

v) Claim must include the ICD_9 code for diabetes (250)

vi) This item may only be claimed once per patient in a consecutive 12 month period

vii) Not payable if 13050 claimed within the previous 12 months for the same diagnosis.

viii) If a visit is provided on the same date the bonus is billed both services will be paid at the full fee.

14051 *incentive for full service GP-annual chronic care bonus (congestive heart failure)*- $125.00

Notes:

i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.

ii) Payable to the general practice full service family physician who has provided the majority of the patients longitudinal general practice care over the preceding year and who has provided an adequate level of guideline based care.

iii) Applicable only for patients with confirmed diagnosis of congestive heart failure.

iv) Care provided must be consistent with the BC clinical guideline recommendations for congestive heart failure and may be billed once the Goals Column, Initial Review (baseline) Column and subsequent column (visit intervals to be determined by physician) have been completed.

v) Claim must include the ICD_9 code for congestive heart failure (4280)

vi) This item may only be claimed once per patient in a consecutive 12 month period.

vii) Not payable if 13050 claimed within the previous 12 months for the same diagnosis.

viii) If a visit is provided on the same date the bonus is billed both services will be paid at the full fee.

If you previously submitted and were paid under fee item 13050-$75.00 for dates of service commencing April 1, 2006 please send an electronic debit request to withdraw the payment and resubmit under fee item14050 or 14051. Claims for April or May 2006 service dates submitted under fee item 13050 after May 4, 2006 and before June 7, 2006 will be paid as 14050 or 14051 at $125.00.

Claims submitted on May 18, 2006 for fee item 13050 for April and May 2006 service dates were inadvertently refused with explanatory code VG. Please do not resubmit as these claims will be reprocessed for payment under the new fee items.

14052 incentive for full service gp-annual chronic care bonus (hypertension) $50.00

Notes:

i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.

ii) Payable to the general practice full service family physician who has provided the majority of the patients longitudinal general practice care over the preceding year and who has provided an adequate level of guideline based care.

iii) Applicable only for patients with confirmed diagnosis of hypertension who do not also have a diagnosis of diabetes mellitus and/or congestive heart failure.

iv) Care provided must be consistent with the BC clinical guideline recommendations for hypertension.

v) May only be billed after the patient has been provided guideline based care for one year. The patient must be given a copy of their flow sheet.

vi) Claim must include the ICD_9 code for hypertension (401)

vii) This item may only be claimed once per patient in a consecutive 12 month period

viii) Not payable if 13050, 14050 or 14051 claimed within the previous 12 months.

ix) If a visit is provided on the same date the bonus is billed both services will be paid at the full fee.

Further information about the annual chronic care bonus items, the clinical guidelines and the flow sheets is available at:
http://www.health.gov.bc.ca/msp/protoguides/gps/index.html or; on the BCMA website:
http://www.bcma.org/public/CDM/CDMIncentivepaymentInfo.htm

3. Family Physician Obstetrical Premium

This premium been allocated to encourage and support low to moderate volume delivery practice. General practitioners performing the first delivery of the day are eligible to receive a 50 per cent bonus on the current value of the fee-for-service delivery payment. The bonus payment is limited to the first delivery per day, up to a maximum of 25 deliveries per calendar year.
Effective December 31, 2005 fee item G14000 will expire and will be replaced by two new fee items. This fee item change was implemented to facilitate physician billings and to assist with any billing problems created by fee item G14000.

Please note, the payment rates of these listings will be adjustment once funding allocations are finalized.

G14004 Incentive for full service general practitioner – obstetric delivery bonus associated with vaginal delivery and post natal care $258.33

Notes:
- *i) Payable to family physician performing the first delivery of the day.*
- *ii) Physician must also be responsible (or share responsibility) for providing patient's general family practice medical care.*
- *iii) Payable only when fee item 14104 billed in conjunction.*
- *iv) Maximum of one bonus per patient delivered, up to a maximum of 25 bonuses per calendar year.*
- *v) Only one obstetrical bonus payable per day, under either FI 14004 or 14009.*

G14009 Incentive for full service general practitioner - obstetric delivery bonus related to attendance at delivery and post-natal care associated with emergency caesarean section $215.17

Notes:
- *i) Payable to family physician performing the first delivery of the day.*
- *ii) Physician must also be responsible (or share responsibility) for providing patient's general family practice medical care.*
- *iii) Payable only when fee item 14109 billed in conjunction.*
- *iv) Maximum of one bonus per patient delivered, up to a maximum of 25 bonuses per calendar year.*
- *v) Only one obstetrical bonus payable per day, under either FI 14004 or 14009.*

Clarification: The 25 bonus limit per year is applicable to any combination of the two new fees (i.e. not 25 of each, but 25 in total)

New explanatory codes have been developed to replace explanatory code NP and to help physician offices identify the reason a claim was debited.

The new explanatory codes are:

NQ The incentive for full service GP obstetrical delivery bonus is payable for the first delivery the GP attends on the date billed.

NR The incentive for full service GP obstetrical delivery bonus is payable to a maximum of 25 bonuses per calendar year

4. <u>One Time Incentive Payments</u>:

GPs who as of April 1, 2006 provided care, are eligible to bill and have billed the incentive payment for at least ten patient with diabetes or congestive heart failure by completing the patient flow sheets since the inception of the program in 2003, and/or performed at least five deliveries (fee codes 14104 or 14109) in the preceding 12 months will receive a one time payment of $2,500;

and;

GPs who as of June 30, 2006 provided care, are eligible to bill and have billed the incentive payment for at least ten patient with diabetes or congestive heart failure by completing the patient flow sheets since the inception of the program in 2003, and/or performed at least five deliveries (fee codes 14104 or 14109) in the preceding 12 month will receive a one time payment of $7,500.

Fee Item 14020

General practitioners who, as of April 1, 2006, have provided care, are eligible to bill and have billed 13050 for at least ten patients with diabetes or congestive heart failure by completing the patient flow sheets since the inception of the program in 2003, and/or have performed at least five deliveries (fee codes 14104 or 14109) in the preceding 12 months, will receive a one time payment of $2500. Any physician who has been paid a specialist consult fee since the inception of this program in 2003 is not eligible for this payment.

If you meet all of the criteria submit your claim as follows:

In the fee item field:	14020
Claim amount:	$2,500.00
In the patients PHN field:	9812530133
In the Last name field:	Gpbonus
In the First initial field:	T
If you require a date of birth, use:	March 6, 1990
For Date of service use:	April 1, 2006

Report the Diagnosis as:	V68 (V68 is the ICD-9 code for "encounters for administrative purposes")

In addition:
General practitioners who, as of June 30, 2006, have provided care, are eligible to bill and have billed 13050, 14050, 14051 or 14052 for at least ten patients with diabetes, congestive heart failure or hypertension by completing a CDM patient flow sheet and /or have performed at least five deliveries (fee codes 14104 or 14109) in the preceding 12 months, will receive a one time payment of $7500. Any physician who has been paid a specialist consult fee since the inception of this program in 2003 is not eligible for this payment.

When submitting your claim use the same information as indicated above except:

Claim amount:	$7500.00
For date of service use:	June 30, 2006

Note: Claims submitted before the date of service or on a date other than indicated will be refused.

More information about the General Practice One Time Incentive Payment is available at: http://www.health.gov.bc.ca/cdm/practitioners/index.html

5. Maternity Care Network Initiative

Eligible practitioners can receive a $1,250 quarterly payment to support a group practice approach to GP provision of obstetrical care. Under the Maternity Care Network Initiative, doctors forming their own shared care networks will work as a team so that at least one physician is always available to deliver their patients.

Fee Item 14010

As part of the new agreement the maternity care network initiative payment under fee item 14010 has been continued for eligible general practitioners.

If you are registered with a maternity care network and meet all of the criteria submit your next claim as follows:

In the fee item field:	14010
Claim amount:	$1,250.00
In the patients PHN field:	9824870522
In the Last name field:	Maternity
In the First initial field:	G
If you require a date of birth, use:	2 November 1989
For Date of service use:	30 June 2006
Report the Diagnosis as:	V26 (V26 is the ICD-9 code for procreative management)

Future claims may be billed on the last day of each calendar quarter (eg. September 30, 2006, December 31, 2006, March 31, 2007…).

Registration forms and more information about the Maternity Care Network are available at: http://www.health.gov.bc.ca/cdm/practitioners/index.html or; http://www.bcma.org.public/CDMIncentivePaymentInfo.htm

6. Patient Management Conference Fee

This fee will be available when the GP is requested by a facility to review ongoing management of a patient in that facility or to determine whether a patient in the facility with complex supportive care needs can safely return to the community or transition to a supportive care or long-term care facility.

Effective April 1, 2006:

14015 General Practice Patient Management Conference: when requested by facility to review ongoing management of the patient in that facility or to determine whether a patient in a facility with complex supportive care needs can safely return to the community or transition to a supportive care or long-term care facility
- per 15 minutes or greater portion thereof..... $40.00

Notes:

i) Refer to Table 1 below for eligible patient populations.

ii) Must be performed in the facility and results of the conference must be recorded in the patient chart.

iii) Payable only for patients in a facility. Facilities limited to: hospital, palliative care facility LTC facility, rehab facility, sub-acute facility, psychiatric facility, detox/drug and alcohol facility, community placement agency, disease clinic (DEC, arthritis, CHF, asthma, cancer or other palliative diagnoses, etc).

iv) Requesting care providers limited to: long term care nurses, home care nurses, care coordinators, liaison nurses, rehab consultants, psychiatrists, CDM nurses, social workers, any healthcare provider charged with coordinating discharge and follow-up planning.

v) Requires interdisciplinary team meeting of at least 3 health professionals in total, and will include family members when available.

vi) Maximum payable per patient is 90 minutes per calendar year. Maximum payable on any one day is 60 minutes.

vii) Claim must state start and end times of the service.

viii) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.

ix) Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.

x) Not payable on the same day for the same patient as the GP complex clinical action plan fee (14016)

xi) Visit payable in addition if medically required and does not take place concurrently with patient management conference. Medically required visits performed consecutive to the Patient Management Conference are payable.

This fee is for patient care conferences taking place in a facility.

Additional information about the Patient Management Conference Fee is available at: http://www.health.gov.bc.ca/cdm/practitioners/index.html

7. Complex Patient Clinical Conference Fee

This fee will be available to GPs for the creation of a coordinated clinical action plan for the care of community-based patient with more complex needs. This fee is payable when coordination of care and collaborative planning with other health care providers patients and possibly family members is required due to the severity of the patient's condition.

Effective April 1, 2006:

14016 General Practice Complex Clinical Action Plan: Creation of a coordinated clinical action plan for the care of community-based patients with more complex needs. Payable only when coordination of care and collaborative planning with other health care providers (e.g. Specialists, psychologists, or counselors, home care or specialty care nurses, physiotherapists, occupational therapists, social workers, specialists in medicine or psychiatry) patients and possibly family members is required due to the severity of the patients condition.) - per 15 minutes or greater portion thereof $40.00

Notes:

i) Refer to Table 1 for eligible patient populations.

ii) Fee includes:
   a) where appropriate, interviewing of, and conferencing with patient, family members, and other community health care providers.
   b) organization and review of appropriate laboratory and imaging investigations, and the administration of other testing (e.g.: Beck Depression Inventory or MMSE) as clinically indicated.
   c) the integration of available information into the formulation of an action plan for the clinical care of that patient in the community, including the provision of Degrees of Intervention or DNR documentation as appropriate.
   d) The care plan must be recorded in the chart and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals will be made, what follow-up has been arranged.

iii) Maximum payable per patient is 90 minutes per calendar year. Maximum payable on any one day is 60 minutes.

iv) Claim must state start and end times of service.

v) Not payable to the same patient on the same date of service as the Patient Management Conference fee (fee item 14015).

vi) Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.

vii) Visit payable in addition if medically required and does not take place concurrently with clinical action plan.

Additional information about the Complex Clinical Action Plan Fee is available at: http://www.health.gov.bc.ca/cdm/practitioners/index.html

8. Table 1: Eligible Patients for the Patient Conference Fees

Table 1: Eligible patients populations for the Patient Management Conference Fee (14015) and the Complex Patient Clinical Action Plan Fee (14016)

i. Frail elderly (ICD-9 code V15)
Patient over the age of 69 years with at least 3 out of the following factors:
- Unintentional weight loss (10 lbs in the past year)
- General feeling of exhaustion
- Weakness (as measured by grip strength)
- Slow gait speed (decreased balance and motility)
- Low levels of physical activity (slowed performance and relative inactivity)
- Incontinence
- Cognitive impairment

ii. Palliative care (ICD-9 code V58)
Patient of any age who:
- Are living at home ("Home" is defined as wherever the person is living, whether in their own; home or living with family or friends, or living in a supportive living residence or hospice); and
- Have been diagnosed with a life-threatening illness or condition; and
- Have a life expectancy of up to six months, and
- Consent to the focus of care being palliative rather than treatment aimed at cure.

iii. End of life (ICD-9 code V58)
Patients of any age:
- Who have been told by their physician that they have less than six months to live; and
- With terminal disease who wish to discuss end of life, hospice or palliative care

iv. Mental illness

Patients of any age with any of the following disorders are considered to have mental illness.

- Mood Disorders
- Anxiety and Somatoform Disorders
- Schizophrenia and other Psychotic Disorders
- Eating Disorders
- Substance Use Disorders
- Infant, Child and Adolescent Disorders
- Delirium, Dementia and Other Cognitive Disorders
- Sleep Disorders
- Personality Disorders
- Developmentally Delayed, Fetal Alcohol Spectrum Disorders and Autism Spectrum Disorders

- Sexual Dysfunction
- Dissociative Disorders
- Mental Disorders due to a General Medical Condition
- Factitious Disorder

Billing Seminar Needs Assessment

The British Columbia Medical Association/Ministry of Health Joint Utilization Committee is evaluating the need for billing seminars **for medical office assistants and physicians** (as appropriate). The seminars would primarily be developed for Medical Office Assistants (MOA's) but would also benefit physicians already in practice and newly registered physicians. The seminars would provide assistance with a wide variety of MOH/MSP administrative and operational information.

1. Would you or someone from your office attend a billing seminar (see list of topics below)?
   ☐ Yes ☐ No

2. Proposed list of topics - please check the box beside each subject you would like included. If a topic that you would like to discuss has not been included please add at the bottom of the list.

- ☐ Accounts Refused – Coverage Problems
- ☐ Alternative Payment Arrangements
- ☐ Anesthesia
- ☐ Audit /Monitoring
- ☐ Billing Integrity
- ☐ Chronic Disease Management
- ☐ Claims Processing System
- ☐ Continuing Care and Nursing Home Visits
- ☐ Cosmetic Surgery
- ☐ Critical Care Team Fees
- ☐ Electronic Debit Requests
- ☐ Emergency Medicine Fees
- ☐ Fee items 00081, 00082, 00083, 00084
- ☐ Out of Country Approval and Billing
- ☐ Hospital Visits
- ☐ Maternity Care
- ☐ Multiple Visits/Services
- ☐ Out of Office Service Charges
- ☐ Primary Care
- ☐ Protocols and Guidelines
- ☐ Reciprocal Billing
- ☐ Referrals
- ☐ Rural Programs
- ☐ Interpret Remittance Statements
- ☐ Submission Codes
- ☐ Uninsured Services
- ☐ Using Note Records Effectively

Other:

_____

_____

_____

3. What are your preferred times and locations?

TIME	LOCATIONS
☐ Daytime	☐ Local Region _____
☐ Evening	☐ Victoria
☐ Weekends	☐ Vancouver

Please complete and FAX this information to:
Medical Services Operations and Policy, Ministry of Health
Fax: 250 952-3133 or; for questions
Telephone: 250 952-1059

Name _____ Physician # _____

Address _____ City _____ Postal Code _____

Contact Person _____ Phone _____ Fax _____

STANDARD OUT-PATIENT LABORATORY REQUISITION

1901

LABORATORY ADDRESS

LAB USE ONLY

BILLABLE TO:
☐ MSP ☐ ICBC ☐ WORKSAFEBC ☐ PATIENT ☐ OTHER:

NAME OF PHYSICIAN & MSP PRACTITIONER NUMBER (or office stamp)

PERSONAL HEALTH NUMBER | DOB: YYYY / MM / DD

SURNAME OF PATIENT | FIRST NAME AND MIDDLE INITIAL

TELEPHONE # (INCLUDE AREA CODE) | GENDER ☐ M ☐ F | PREGNANT ☐ Yes ☐ No | IF STAT ORDER, PLEASE PROVIDE CONTACT PHONE NUMBER

ADDRESS | CITY/TOWN | POSTAL CODE | COPY RESULTS TO:

DATE & TIME OF COLLECTION | HOURS SINCE LAST MEAL | DATE & TIME LAST DOSE | PHLEBOTOMIST INITIALS

DIAGNOSIS AND INDICATIONS FOR GUIDELINE PROTOCOL AND SPECIAL TESTS

CURRENT MEDICATION

NOTE: PROVINCIAL GUIDELINES / PROTOCOLS SHOULD BE CONSULTED FOR TESTS IN ITALICS / SHADED BOXES.
www.hlth.gov.bc.ca/msp/protoguides/index.html

HEMATOLOGY

☐ WBC

☐ Hemoglobin ☐ Hemoglobin only

☐ Hematology profile
Includes Hb, WBC, platelets, Hct, RBC indices, and differential when indicated

☐ PT-INR

Warfarin ☐ Yes ☐ No

CHEMISTRY

☐ Glucose - fasting

☐ GTT - Gestational diabetes screen

☐ GTT - Gestational diabetes confirmation

Pregnancy test ☐ Urine ☐ Serum

☐ Therapeutic drug concentrations:

Specify drugs: _____

_____

☐ Toxicity suspected

☐ *TSH* - Provide indication above if additional thyroid test ordered.

☐ PSA MSP billable ☐ Yes ☐ No *(patient pays)*
Provide indication above

☐ *Ferritin* ☐ *Iron & transferrin saturation*
Provide indication above if ordered together

LIPIDS

Major risk factor(s) for CAD ☐ *Yes* ☐ *No (patient pays)*

☐ *Total cholesterol*

☐ *Triglycerides*

☐ *HDL-cholesterol*

☐ *LDL-cholesterol (calculated)*

MICROBIOLOGY

TEST: ☐ Bacterial culture ☐ Gram stain
(list current antibiotics above)

SITE: ☐ Nose ☐ Sputum ☐ Throat ☐ Stool

☐ Other _____

TEST: ☐ Fungus culture ☐ Fungus direct exam (KOH prep)

SITE: ☐ Skin ☐ Nails

☐ Other _____

URINALYSIS / URINE CULTURE

☐ *Macroscopic (dipstick)* ☐ *Microscopic*

☐ *Macroscopic* * *microscopic if dipstick positive*

☐ *Macroscopic & microscopic, provide indication above*

☐ *Urinalysis* * *urine culture if pyuria or nitrite present*

☐ *Urine culture (list current antibiotics above)*

GENITAL SPECIMENS

Cervicitis ☐ *Chlamydia (special swab)* ☐ *Gonorrhea*

Urethritis ☐ *Chlamydia (special swab)* ☐ *Gonorrhea*

Vaginitits ☐ *Initial (smear only)*
☐ *Recurrent/chronic (smear & culture)*
☐ *Trichomonas*

Vagino-anorectal, pregnancy ☐ *(group B strep only)*

Urine ☐ *Chlamydia*

VIRAL HEPATITIS

Note: testing will be according to the hepatitis guideline/protocol unless specifically ordered under additional tests/instructions.

☐ *Acute* ☐ *Previous / Chronic* ☐ *B carrier*

STOOL - OVA & PARASITES

☐ *One specimen* ☐ *Two specimens (high risk)*

SPECIAL TESTS

☐ HIV Serology - Non-Nominal Reporting

☐ HIV Serology - Nominal Reporting

*** one box must be marked**

Patient has legal right to choose nominal or non-nominal reporting.

ADDITIONAL TESTS / INSTRUCTIONS

INSTRUCTIONS TO PATIENTS (see reverse)
Other instructions:

SIGNATURE OF REQUESTING PHYSICIAN

TELEPHONE REQUISITION TIME | INITIALS OF RECORDER | DATE SIGNED (YYYY / MM / DD)

STANDARD OUT-PATIENT
BONE DENSITOMETRY REQUISITION

X-RAY FACILITY ADDRESS	X-RAY USE ONLY

BILLABLE TO: ☐ MSP ☐ ICBC ☐ WORKSAFEBC ☐ PATIENT ☐ OTHER:			**NAME OF PHYSICIAN & MSP PRACTITIONER NUMBER** (or office stamp)
PERSONAL HEALTH NUMBER	DOB: YYYY / MM / DD		
SURNAME OF PATIENT	FIRST NAME AND MIDDLE INITIAL		
TELEPHONE # (INCLUDE AREA CODE)	GENDER ☐M ☐F	PREGNANT ☐Yes ☐No	
ADDRESS / CITY/TOWN / POSTAL CODE			COPY RESULTS TO:

APPOINTMENT DATE	APPOINTMENT TIME

PERTINENT HISTORY

PREVIOUS BONE DENSITOMETRY ☐ YES ☐ NO	LOCATION	DATE
PREVIOUS LUMBAR SPINE X-RAYS ☐ YES ☐ NO	LOCATION	DATE

EXAMINATION REQUESTED

☐ **SCREENING BONE DENSITOMETRY**

This is not an MSP insured service; payment is the responsibility of the patient.

☐ **DIAGNOSTIC BONE DENSITOMETRY FOR WOMEN**

Covered by MSP but an indication MUST be checked. Indication is as defined in the *Bone Density Measurement in Women*, Medical Services Commission and BCMA, May 1, 2005.

Appropriate indications: BMD is only indicated if it is likely to alter treatment and is considered an MSP-insured service if there is one major OR two minor risk factors for osteoporosis.

MAJOR RISK FACTORS	MINOR RISK FACTORS
☐ Age ≥ 65 years	☐ Past history of clinical hyperparathyroidism
☐ Low trauma vertebral compression fracture	☐ Chronic anticonvulsant therapy
☐ Low trauma fracture over age 40	☐ Low dietary calcium intake
☐ Family history of osteoporotic fracture	☐ Smoking
☐ Current systemic glucocorticoid therapy of > 3 mos duration	☐ Excessive alcohol intake
☐ Malabsorption syndrome	☐ Excessive caffeine intake (e.g. >4 cups coffee/day)
☐ Primary hyperparathyroidism	☐ Weight < 57 kg
☐ Hypogonadism	☐ Short term weight loss > 10% from weight at age 25
☐ Early menopause (before age 45)	☐ Chronic heparin therapy
	☐ Rheumatoid arthritis

☐ **FOR MALES AND CHILDREN**

Other situations where information on bone density is considered essential to decisions about therapy.

☐ **FOLLOW-UP BONE DENSITY MEASUREMENTS**

The use of BMD follow-up measurements is controversial. In general, they are not considered medically necessary prior to two years after the original measurement and only if it is likely to alter patient management. The following exceptions apply:

- in patients receiving ≥ 7.5 mg prednisone daily or its equivalent for three months consecutively (who may require repeat scans at up to six month intervals while on treatment).
- in patients with existing fractures or with very low bone density in whom an earlier examination may be indicated.

TELEPHONE REQUISITON TIME	INITIALS OF RECORDER	DATE SIGNED (YYYY / MM / DD)	SIGNATURE OF REQUESTING PHYSICIAN

STANDARD REQUISITION FOR ADULT POLYSOMNOGRAPHY OR MULTIPLE SLEEP LATENCY TEST

(To be completed by specialist consultant with interest in sleep medicine)

FACILITY ADDRESS

FACILITY USE ONLY

BILLABLE TO:
☐ MSP ☐ ICBC ☐ WORKSAFEBC ☐ PATIENT ☐ OTHER

NAME OF PHYSICIAN & MSP PRACTITIONER NUMBER (or office stamp)

PERSONAL HEALTH NUMBER

DOB: YYYY / MM / DD

SURNAME OF PATIENT

FIRST NAME AND MIDDLE INITIAL

DAYTIME TELEPHONE # (INCLUDE AREA CODE)

EVENING TELEPHONE # (INCLUDE AREA CODE)

GENDER ☐M ☐F

ADDRESS

CITY/TOWN

POSTAL CODE

COPY RESULTS TO:

PERTINENT HISTORY

EPWORTH SLEEPINESS SCALE SCORE (DATE)
/24

HOME OXIMETRY TEST RESULTS ☐YES ☐NO IF YES, ATTACH REPORT AND SPECIFY:
LOCATION
DATE

PREVIOUS POLYSOMNOGRAM ☐YES ☐NO IF YES, ATTACH REPORT AND SPECIFY:
LOCATION
DATE

PREVIOUS MULTIPLE SLEEP LATENCY TEST ☐YES ☐NO IF YES, ATTACH REPORT AND SPECIFY:
LOCATION
DATE

TREATMENT INITIATED (E.G., CPAP, ORAL APPLIANCE) - DATE AND RESULTS

DATE

TESTING REQUESTED

DIAGNOSTIC POLYSOMNOGRAM

INDICATION:
☐ SUSPECTED SLEEP DISORDERED BREATHING
☐ SUSPECTED PERIODIC LIMB MOVEMENT DISORDER
☐ OTHER (SPECIFY)

FOLLOW-UP:
☐ PATIENT WITH SLEEP DISORDERED BREATHING TREATED WITH EITHER CPAP OR ORAL APPLIANCE
☐ PATIENT WITH EITHER NARCOLEPSY OR PERIODIC LIMB MOVEMENT DISORDER ON APPROPRIATE TREATMENT

DIAGNOSTIC POLYSOMNOGRAM AND MULTIPLE SLEEP LATENCY TEST
☐ SUSPECTED NARCOLEPSY OR IDIOPATHIC HYPERSOMNOLENCE
☐ PATIENT WITH SLEEP DISORDERED BREATHING AND PERSISTANT DAYTIME SLEEPINESS DESPITE EFFECTIVE TREATMENT

PRIORITY

☐ **1 (URGENT)** Patients with:
- suspected sleep disorder; and
- major daytime sleepiness (ESS 10 or greater); and
- one or more of the following
  - stable co-morbid disease[1]; or
  - high risk occupation[2]; or
  - overnight home oximetry which reveals >10/hour 4% desaturations

☐ **2** Patients with:
- suspected sleep disorder; and
- major daytime sleepiness (ESS 10 or greater); ***but***
- no co-morbid disease or high-risk occupation

☐ **3** Patients with:
- suspected sleep disorder; ***but without***
  - major daytime sleepiness (i.e., ESS <10); or
  - co-morbid diseases; or
  - high-risk occupation

[1] *Co-morbid disease*: ischemic heart disease, cerebrovascular disease, congestive heart failure, obstructive/restrictive lung disease, pulmonary hypertension, hypercapnic respiratory failure.

[2] *High-risk occupations*: truck, taxi, bus drivers; railway engineers, airline pilots, car drivers who admit to have fallen asleep while driving within the last two years (all patients who are considered high risk should be told to cease their occupation and personal driving until after their polysomnogram has been reviewed and/or appropriate treatment has commenced).

NOTE ANY CO-MORBID DISEASE OR HIGH-RISK OCCUPATION AND OTHER PERTINENT CLINICAL INFORMATION

DATE SIGNED (YYYY / MM / DD)

SIGNATURE OF REQUESTING PHYSICIAN